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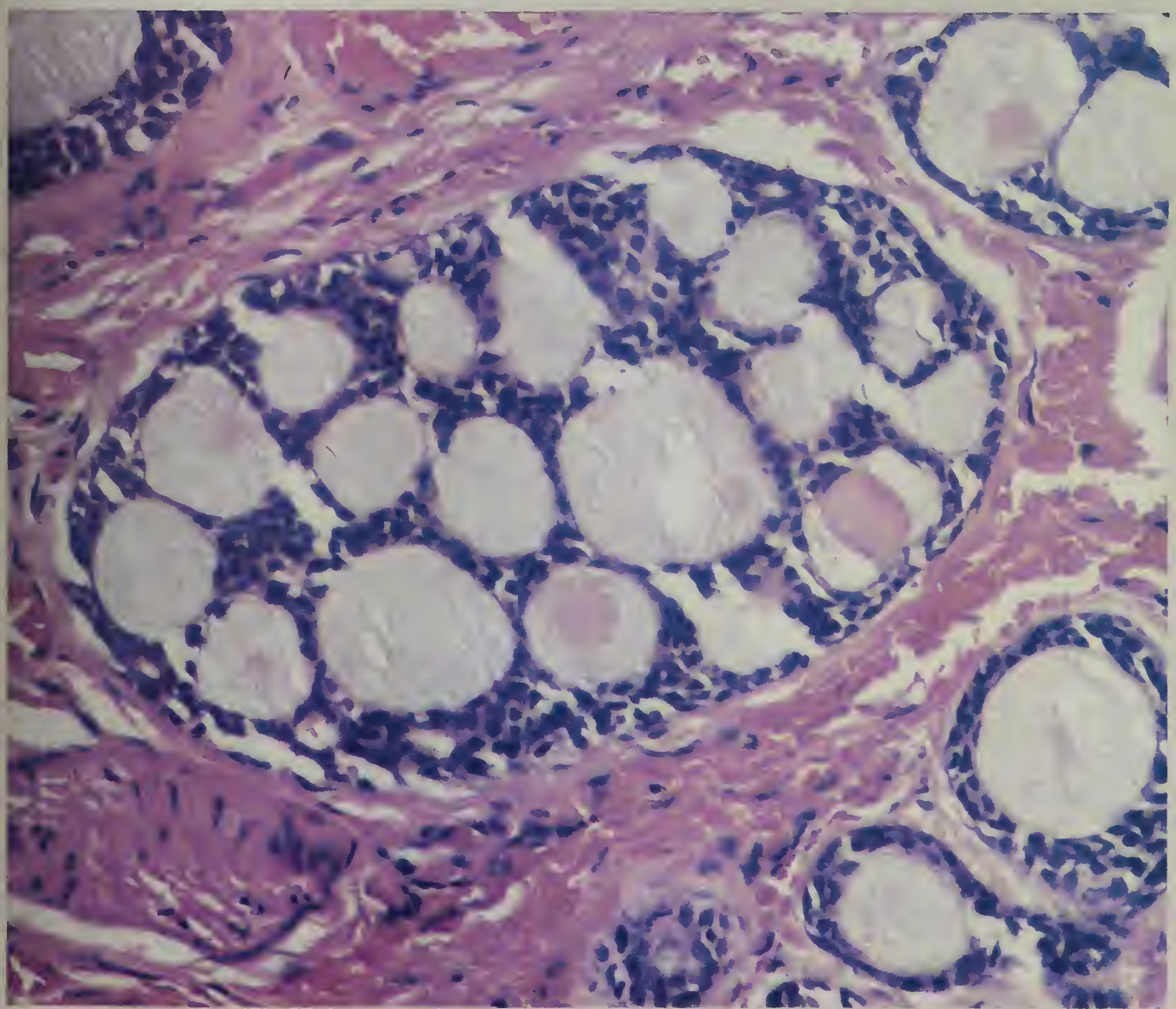
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FMF IMPAIRED PHYSICIANS COMMITTEE NEWSLETTER

Published by the Committee on Impaired Physicians / Florida Medical Foundation / P. O. Box 2411 / Jacksonville, Florida 32203

January 1985 "Doctors Helping Doctors" Vol. 2 — No. 1

Governor to Receive Commission Report

The Governor's Commission on Alcohol and Drug Concerns is scheduled to present its report and recommendations to Governor Graham within the next few weeks.

The Commission met in Tallahassee last month to sift through various recommendations and concepts presented at previous meetings and a series of hearings conducted around the state during the past year. The report is expected to include, among other things, several recommendations for legislative action and proposals for increased attention to drug education in the state's school system.

Commission members include Joseph H. Deatsch, M.D., of Jacksonville, Chairman of the FMA Committee on Substance Abuse, and State Senator William G. (Doc) Myers, M.D., of Hobe Sound.

5 Treatment Centers on Approved List

Physicians and other health care professionals admitted for treatment under the IPP are admitted to one of five facilities in Florida or to an approved facility in another state.

The Committee on Impaired Physi cians has approved the following treatment facilities in Florida for participation in the program:

- South Miami Hospital, Miami
- Horizon Hospital, Clearwater
- Palm Beach Institute, West Palm Beach
- Lakeland Regional Medical Center, Lakeland
- Mt. Sinai Medical Center, Miami Beach

Treatment facilities affiliated with the impaired physicians programs of the Mississippi and Georgia medical associations are among out-of-state centers used from time to time.

FMA Chemical Dependency Section Features Cocaine Epidemic Update

"Substance Abuse: Consequences and Implications" will be the theme for the fifth annual FMA Section on Chemical Dependency at the FMA Annual Meeting in May.

The program will include an update on cocaine and a discussion of medico-legal implications of physician substance abuse, according to Arvey I. Rogers, M.D., of Miami, and E. Joan Barice, M.D., of Palm Beach Gardens, Program Co-chairs. The program will be presented from 1:00 p.m. to 4:00 p.m. on Thursday, May 2, at the Diplomat Hotel in Hollywood under the sponsorship of the Florida Medical Foundation Committee on Impaired Physicians.

"There are medico-legal implications of physician substance abuse which extend far beyond the recognition of physician impairment," Dr. Rogers said. "These implications will be explored by a panel of experts. Audience participants should develop an appreciation of these issues, an understanding of how they impact on the over-all efforts to rehabilitate substance abusers, and some insight regarding the role physicians can play individually and as an organized group to alter attitudes and legislation."

Charles V. Wetli, M.D., Deputy Chief Medical Examiner of Dade County, will be on the program to update his informative and well-received talk on cocaine last year. His topic will be: "Update Cocaine: A Continuing Craze of the '80s."

Dr. Barice, President of the Florida Chapter of the American Medical Society on Alcoholism, will moderate the physician substance abuse panel.

Panelists will include Richard J. Feinstein, M.D., of Miami, President of the Florida Board of Medical Examiners; Dolores A. Morgan, M.D., Medical Director of the FMA-FMF Impaired Physicians Program; and others to be announced.

Physicians attending the program may receive three hours of AMA Category I CME credit.

Newsletter Observes First Anniversary

January is a red-letter month for the Committee on Impaired Physicians, which is observing two anniversaries during the month.

It was four years ago this month that the IPP began accepting patients for treatment.

One year ago, the *FMF Impaired Physicians Newsletter* was born, and this is the fifth issue.

The *Newsletter* is distributed quarterly (in January, April, July and October) to all members of the Florida Medical Association as an insert to *The Journal* and to state medical association officials and others concerned with chemical addiction throughout the United States.

S.E. Drug Conference Set for May 8-10

The 1985 Southeastern Conference on Prescription Drug Abuse will be held May 8-10 at Charleston, South Carolina.

Joseph H. Deatsch, M.D., of Jacksonville, Chairman of the FMA Committee on Substance Abuse, is a member of the program committee for the conference, which is expected to attract more than 150 participants from Georgia, Alabama, Florida, Mississippi, South Carolina, Tennessee, Kentucky, North Carolina and other states outside the southeastern region.

Conference Coordinator Gene J. Sausser, Ph.D., said a registration fee of $35.00 will be charged.

Additional information may be obtained by contacting Dr. Sausser at the Department of Neuropsychiatry, University of South Carolina School of Medicine, P.O. Box 202, Columbia, SC 29202.

Program Examines Role of Psychiatrists

A training conference for all health professionals involved in treating addictive diseases will be held in Atlanta, Georgia, this spring.

The Ritz-Carlton Buckhead will be headquarters for the program, "Addictionologists and Psychiatrists: Partners in the Management of Addictive Diseases," April 10-13. Sponsors are the Ridgeview Institute in Smyrna, Georgia, and the American Medical Society on Alcoholism, which has certified the program as meeting the requirements for 20 hours of AMA Category I CME Credit.

A half-day on April 11 will be devoted to outpatient treatment for cocaine addiction, a discussion of the cocaine epidemic, and problems associated with cocaine abuse.

Other talks will be devoted to using spirituality as a treatment, a psychiatric perspective on the dynamics of addiction, chemical dependence and sexuality and others.

Registration fee for the entire conference is $325.00, which includes three continental breakfasts, luncheon, reception, banquet and breaks. Registration for one day is $150.00.

Additional information may be obtained by contacting: U.S. Journal Training, Inc., 2119-A Hollywood Boulevard, Hollywood, FL 33020.

Dr. Hankes Directs South Miami Program

Lynn R. Hankes, M.D., has assumed duties as Director of the Addiction Treatment Unit at South Miami Hospital, succeeding Dolores A. Morgan, M.D.

Dr. Hankes formerly headed the addiction unit at Lakeland Regional Medical Center.

Dr. Morgan Speaks To Women Physicians

Dolores A. Morgan, M.D., of Miami, Medical Director of the FMA-FMF Impaired Physicians Program, will be a guest speaker at the Florida Medical Association's Leadership Skills Seminar for Women Physicians next month.

Dr. Morgan's topic will be "Dealing with Stress and Avoiding Burnout." The half-day seminar will be on Friday morning, February 1, at the Airport Marriott Hotel in Tampa.

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This month's cover of *The Journal* was submitted by S. Allen Mullen Jr., M.D. from Jacksonville, demonstrating adenoid cystic carcinoma of the parotid gland.

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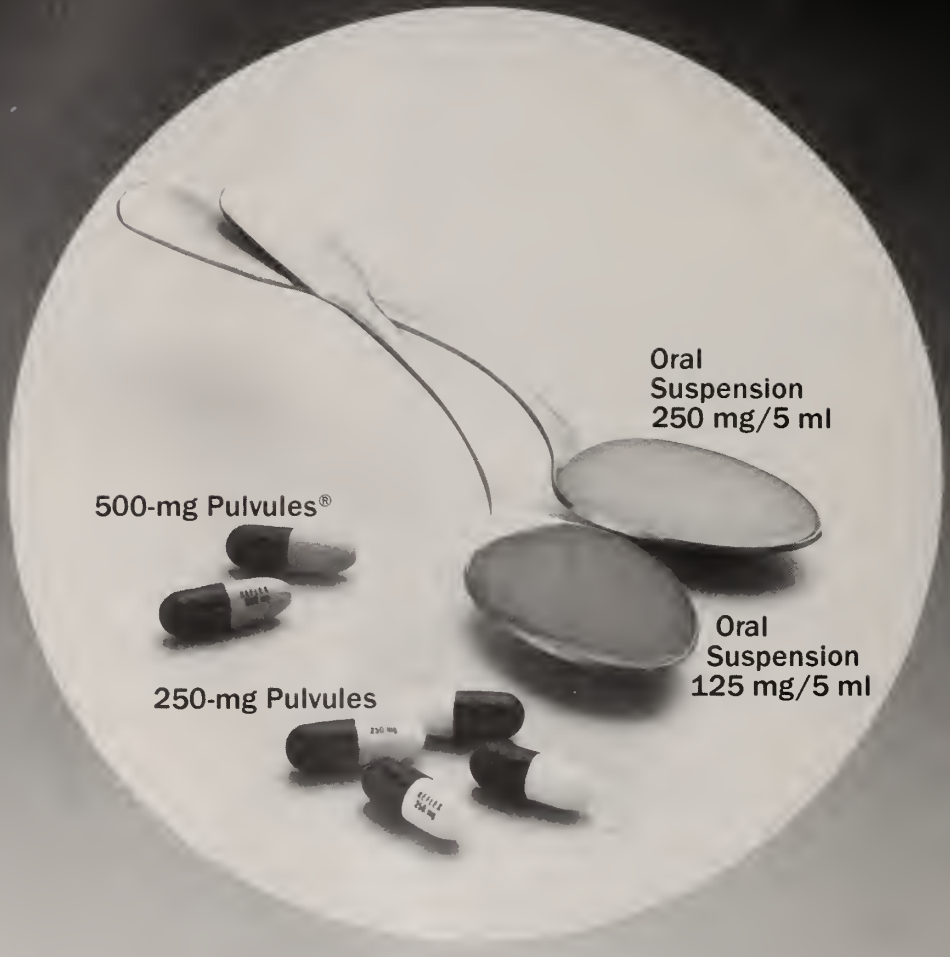
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PRESIDENT'S PAGE

FMA meeting the legislative challenge



What kind of legislative arm does the Florida Medical Association need in 1985? This question is best answered by the following excerpts from the report of James H. Sammons, M.D., Executive Vice President of the AMA, as presented at the opening session of the AMA House of Delegates in December at the Interim Meeting:

> Nothing would please me more than to tell you that we are soon to enter upon a new era in which we will quickly solve all our problems, achieve all our goals and confound all our enemies. Unfortunately, we are a long way from finding a New Jerusalem, and I am afraid that we shall have to continue doing business where we are — in the real world.
>
> Accordingly, I think it appropriate to start this periodic report on our organization with a word about that world. It is, above all, a complex and difficult environment replete with powerful, well-established organizations that include the federal Congress, the Department of Health and Human Resources, private industry, a cluster of regulatory agencies and the judiciary. Those institutions, moreover, are peopled with strong-willed men and women with agendas that do not necessarily coincide with our own. We must also keep in mind that we live in a society with already high expectations and that we are governed by political organizations that are highly sensitive to the changing needs and desires of a restless public. The sea in which we must swim teems with other and vigorous forms of life.
>
> To be effective in the real world, to deal successfully with other institutions, to meet new public demands, to respond to changing societal needs, is not the simple matter some people think it is. When issues arise, they are generally resolved through a parliamentary process, a process characterized more by accommodation and compromise than by clear-cut victories and defeats. To operate successfully in this world requires understanding the art of the possible, generous measures of restraint and sophistication, plus patience and staying power.
>
> In periods of worry and frustration such as we are experiencing now, it is often tempting to try the pat and simple solutions that are frequently offered, to consider changes that really have little relevance to the difficulties at hand. The usual result of such actions is the throwing out of babies with the bath water. Rather than yield to simplistic suggestions, it has usually been more effective policy, in my experience, to stay focused on our problems, to work for a wider understanding of our viewpoint, to develop allies to aid us in our causes and to seek modification of objectional statutes or pursue their overturn in the courts.

It is clear that we need the strongest and most effective legislative arm that we can develop. The revolution that is currently sweeping the health care delivery system is being fueled by legislative action at both the state and the national level. The Equitable Life Assurance Society healthcare survey that was carried out a few months ago indicates that 75% of the American public believes that the health care system in this country needs major changes. Fifty percent said there are some good things in our health care system, but fundamental changes are needed to make it work better. This view is shared by a majority of health insurance executives (80%), corporate benefits officers (79%), union leaders (69%), and hospital administrators (56%). Cost and access are of paramount concern to the American public. Quality of care, along with cost and access, are major concerns to physicians. Physicians believe that quality of care and access are being threatened by overwhelming concern over cost containment. Every physician in Florida in 1985 is faced with changes in his practice that are disruptive both to his peace of mind and economic future.

Physicians' response to these changes and to ominous legislative initiatives must be based on a unified group rather than individual action. Physicians who chose to throw up their hands in fear and frustration, and drop out of their county and state medical societies and the AMA will find themselves isolated, and will only succeed in further exacerbating the turbulent times ahead for themselves and their colleagues. In the legislative arenas in 1985, divisiveness among medical constituencies will bring great joy to politicians and legislators and great sorrow to members of this constituency.

Congress is now considering recommendations for a continued freeze on physicians' fees and a freeze on hospital charges for Medicare patients. A special commission is to report to the Congress by July 1, 1985 on proposed changes in reimbursement of physicians for Medicare patients. The changes that are receiving the most attention would involve placing physicians under prospective payment, such as the DRGs, or using relative value scales for reimbursement. It seems unlikely that either of these systems will be adopted during 1985, but it is likely that one or another may be passed by Congress in 1986. Government regulations, like the Baby Doe regulation, are taking away the decision-making authority of the physician in patient care. PROs are telling physicians where services to patients should be rendered and HCFA has now sent out a request for a proposal for a "Super PRO."

The reaction of legislators at the state level to the proposed freeze on fees for physicians and charges for hospitals for Medicare patients will be violent as third party payors, business coalitions, and businesses try to minimize the cost shift that will inevitably be passed on to private patients. Proposals for rigid rate setting for hospitals and all payor systems for reimbursement to physicians are very likely.

Allied health groups continue their efforts to preempt segments of medicine for themselves. We have experienced for a long time the efforts of chiropractors, optometrists, and psychologists to achieve this goal. We are now seeing other groups getting into the act. No doubt the pharmacists and optometrists will be back in 1985 with their health care consultants and prescribing bills, which would give the pharmacists the legal authority to diagnose and prescribe, and optometrists the right to prescribe, providing both with access to the third party reimbursement system. I also learned during the recent state legislative conference sponsored by the AMA of another group — the massage therapists. This group now has 28 schools operating in the United States, three thousand members, and is licensed in 12 states. It is not yet clear to me just how a massage therapist would fit into the health care delivery system, but my understanding of the services that massage parlors provide would suggest that they should not be eligible for participation in third party reimbursement.

One common characteristic of all these allied health groups as they seek to establish a place for themselves in health care delivery, is an effort to first obtain licensure or legal certification and then to seek access to the third party reimbursement system, followed by mandated coverage in all health insurance contracts.

Last year, the FMA established a Committee on Health Manpower to provide expertise in dealing with the increasing number of allied health groups who are attempting to expand their activities by legislative action.

Our major problem with the professional liability crisis continues, of course, and resolution of this problem remains a top priority of the FMA. Bills to resolve this problem will be considered again by the Congress and our State Legislature.

The Florida Medical Association has had a legislative program for many years. In 1969, the FMA established a Capital Office in Tallahassee with a full-time legislative director and supporting staff. Because of the early realization of the relationship between effective political action and successful legislative efforts, the FMA was one of the first state medical associations to establish a political action committee (FLAMPAC). Field offices of the FMA with field directors are now located in Tallahassee, Tampa, Orlando, and Miami.

A key man system (key contact program) was developed many years ago with a physician designated as the key man for each member of the Legislature and Congress. Over the last decade, the FMA has also developed a strong working relationship with the FMA Auxiliary in both political and legislative activities. The Auxiliary has become a very strong force in community action and has established a comparable key contact system which works in close cooperation with that of the FMA. The Auxiliary also established a LegsAlert system that has proven to be very effective on behalf of the FMA in dealing with legislative issues which require immediate action.

Our experiences in the legislative sessions in 1983 and 1984 relative to the professional liability issue and our recent experience with Amendment 9, indicated clearly that we needed to carefully examine the legislative arm of the FMA to see whether it is meeting the demands of a rapidly changing environment.

Your Board of Governors, therefore, authorized a review of the legislative program. A team of consultants consisting of Mr. Bill Roberts, AMA Division of Medical Society Relations; Mr. Bob Klinglesmith, Associate Executive Director of the Kentucky Medical Association; and Mr. Greg Hooser, Legislative Counsel of the Texas Medical Association were asked to come to Florida and make a detailed on-site review of our legislative and political education activities. This review was to include the FMA's legislative, PAC,

field services activities, its relationships with the Auxiliary, county and specialty medical societies, and other groups in the health field that have legislative interests and concerns.

The review has now been completed and we have just received a detailed report which indicates that generally the FMA's legislative efforts have been historically very effective, and with the exception of its tort reform effort, compares very favorably with that of most other state medical societies. We must recognize, however, in light of Dr. Sammons' remarks, that Florida is now a bell weather state for change. Therefore, we must continue to respond to the rapid, revolutionary changes that are occurring, and our legislative program should be strengthened in every way possible.

This report and the recommendations of the consultants have received very careful review, and steps are already underway to implement the recommendations which include:

1. Careful evaluation of all staff responsibilities for the FMA legislative and political education activities with appropriate action as necessary to clarify and delineate the role, lines of authority and responsibilities and functions of the FMA headquarters, capital and field offices to ensure the best possible coordination and operational efficiency in carrying out these activities.
2. Expand the responsibilities of the Council on Legislation in carrying out the policies of the House of Delegates using general guidelines established by the Board of Governors.
3. Strengthen working relationships with county medical societies with these efforts directed both at the executives of the county medical societies and the physician members.
4. Stengthen and expand the cooperative efforts with the Auxiliary in our legislative and political education activities.
5. Develop a better working relationship with specialty societies and their lobbyists, if these societies have such lobbyists.
6. Develop a better working relationship with other groups such as business organizations, labor unions, civic and senior citizen organizations.
7. Improve liaison with the executive and regulatory branches of the Florida Government.
8. Incorporate in the FMA legislative program issues other than those that are perceived by the public and the legislature to be solely for the benefit of physicians.
9. Expand FLAMPAC activities to include more assistance to candidates such as benchmark surveys, demographic studies, independent expenditures and more physician and spouse participation in the candidates' campaigns.
10. Maximize efforts to keep physicians informed of the Association's legislative programs and activities.

I believe that this analysis and refinement of the legislative arm of the FMA will greatly enhance our legislative capability in 1985 and in the future, to cope with the numerous, complex, and at times the seemingly overwhelming legislative problems that face us. We will not win on all the issues, but our chances of winning will be greatly improved.

Frank E. Coleman MD

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A covenant for 1985

The profound immoralities of our time — cruelty, indifference, injustice and the use of exploitation of others — as a means rather than as ends in themselves, produces poverty, racism, greed, broken families, blatant vulgarity and social indifferences, all of which needs to be countered and overcome.

In contemplation, who does not want a better community for himself or his progeny who does not want the opportunity to be properly compensated for working at what he loves most, and who does not want a world in which nations live at peace with their neighboring nations. What better way is there to accomplish this than to resolve to be better than we are. In this wish to change to something different, is there not the beginning of a kind of growth since changing conditions for the better are not accomplished by doing more than we can do without first becoming more than we are. Each man is the sum of his own actions and the worth of one's life may not always so much be judged by what he does for others but rather what others do because of the example set. The measure of a man is not only what has come out of his life but also how he has inspired others, living as inspiration to animate future generations. What is decisive is the set of values one lives for, the strengths and steadfastness one draws from one's experience, the reaching out for growth rather than the mere grasping of power and possesions, or pleasure; for true satisfaction in life comes not from the accumulation of money or material goods but rather from the realization of one's work well done.

In the new year there will be a world wide over supply of physicians, increasing medical activities of nonphysician health care providers, increasing emphasis on hospital management as a business enterprise and changing patterns of reimbursement from government and third party payors. Most of the time laws follow and reflect social values, so that legal implications for the practice of medicine will depend on how society values and perceives physicians. Does the public see our profession as made up of individuals selflessly committed to healing the sick and comforting the suffering with compassion or does society see the physician as a highly trained technical businessman who is in practice only to maximize his income and who has little interest in the needs of those whom he treats? If the latter is true, then the law will frown on physicians and the indications for the independent practice will be bleak.

We belong to a profession now passing through one of its greatest crises. Daily, new ideas, new restraints and new calls for service will appear to us. Hopefully in the new year each of us will continue the highest standards in medical education, medical research and in providing access to health care.

Clyde M. Collins, M.D.
Jacksonville

The right to health care

The right of all Americans to health care has taken its place among other great American rights such as freedom of speech and freedom of religion. I first heard that health care was a right about 15 years ago, presumably a pronouncement from someone like Ted Kennedy. The media, consumer groups, and the political establishment embellished this cause and, thus, a new right was born.

I believe that the right to health care means that all Americans are entitled to the availability of quality health care. Unfortunately, what has evolved is the right to free quality health care. Labor unions and other organized groups have for years negotiated first dollar coverage as part of their benefit packages. Companies now find themselves paying astronomical health insurance premiums to provide these benefits to patients who have traditionally been insulated from the costs of health care and have no incentive to control costs, let alone to urge their doctor to hold down costs. How often have I heard, "Spare no expense, Doc. I've got great insurance." The demand for free health care transcends all ages, but the Medicare age group seems to be the most vocal. Perhaps a short lesson about the workings of Medicare is in order to educate the roughly 200,000,000 of us who are too young to be on Medicare, but are paying the bills to keep the system solvent.

Contrary to popular belief, Medicare is not welfare. It was not conceived as welfare in 1964 and is not welfare now. Medicare is simply an insurance plan with a budget this year of $76,000,000,000. A small premium is deducted from social security checks, and in return patients are responsible for a $75 annual deductible toward physician bills and 20% that Medicare does not pay. There is also a deductible for the first day of hospitalization. Supplemental insurance coverage can be purchased that will even pay those amounts that Medicare does not cover for both hospital and physician charges. It is a myth that senior citizens will "lose their life savings" to catastrophic medical bills, as Medicare will cover most bills and every physician and hospital I know will work with anyone truly in need. In an effort to save money, Medicare has gradually decreased the amount they approve so that now they pay 80% of an amount that many times is nowhere near the usual fee. The senior citizens, of course, blame the physicians for the fact that they now must pay more out of pocket, when it is really the government's fault because they cannot deliver on their promise. Since its inception the program has allowed a physician and patient two choices of payment. Either a patient can pay the doctor the full amount of his charge and collect from Medicare 80% of the amount approved, or by "taking assignment," Medicare sends a check directly to the doctor for the same 80% of the amount approved and the patient is responsible for the other 20%. By law the doctor cannot bill the patient for his entire fee if he takes assignment unless his fee is equal to the amount approved by Medicare. The decision to take assignment can be made on an individual basis and indeed even to the extent of taking assignment for one service but not for another on the same patient. For years senior citizen groups have lobbied congress to require all doctors to take assignment and thus, prevent them from billing patients for their full fee. Senior citizens would, thus, save money that could be spent for other needs: in some cases food; in other cases Cadillacs. However, by law, even if mandatory assignment was implemented, patients would still be responsible for some of the bill. In the past few years, as senior citizen groups have become more aggressive, they are even objecting to paying the 20% that they are legally obligated to pay. They are in essence demanding government financed, free health care.

Hardly a day goes by without reading that the Medicare system is going bankrupt. Social security taxes paid by the working people of the country are high enough now and slated to go even higher to cover the short fall in the system. The social security system accounts for 25% of all federal spending. Presently 3.2 people pay into the system for every 1 person drawing money out of the system. In 20 years that ratio will be 2:1. Solutions to the inevitable Medicare bankruptcy include raising the eligibility age from 65 to 67, and gradually raising the deductible. But, perhaps the best solution to Medicare's problems does not stand a chance of serious consideration. The system could become solvent by applying a means of test to benificiaries and force those who could pay for health insurance to pay for health insurance. I have no objection to the truly needy receiving government financed health care, but senior citizen groups would have us believe that everyone over the age of 65 is on a fixed income, nearly indigent, and in need of free health care. Since when is one needy simply because of his age? I am certain that there are some wealthy senior citizens. Why are they getting government subsidized medical care? Why should the retired bank president living on a "fixed income" of interest and dividends from his corporate retirement plan receive government subsidized health care? At the very least he should contribute more to the system than a person at or below the poverty level. After all, the rest of us are being asked to make sacrifices in order to save the Medicare system. Since when did we decide to offer free quality health care to a group based soley on age?

If health care is to be a right then let it be a right of accessibility for all Americans. Those truly in need without regard to age should receive government assistance. Employers should be required to offer health insurance guarenteeing at least minimum coverage to their employees. Senior citizens who can afford to pay should pay some of the costs of their medical care. The right to health care carries with it responsibilities we all must share.

Lee A. Fischer, M.D.
West Palm Beach

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New study reveals no interaction betwee



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In a study evaluating the influence of propoxyphene coadministration on the pharmacokinetics of the oxidatively metabolized benzodiazepines Xanax® (alprazolam) ℂ and Valium® (diazepam) ℂ, and a benzodiazepine metabolized by conjugation, Ativan® (lorazepam), the following results were reported:

with Xanax, propoxyphene caused a large and highly significant prolongation of half-life and impairment of total metabolic clearance.[1]

in the case of Valium, propoxyphene produced a small but not statistically significant impairment of clearance.[1]

propoxyphene had no apparent effect on the distribution, half-life or clearance of Ativan.[1]

In this randomized crossover study, eight healthy male and female volunteers received single oral doses of alprazolam (1 mg), six received single IV doses of diazepam (10 mg), and five received single IV doses of lorazepam (2 mg), once in a drug-free control state and again during coadministration of propoxyphene (65 mg q6h). Consistent with previous findings, this study evidences that Ativan does not interact with drugs that undergo oxidative metabolism.[2-5] In contrast to most other benzodiazepines, Ativan does not compete for the cytochrome P-450 enzyme system.

The clinical implications of the pharmacokinetic interaction, or non-interaction, of propoxyphene with benzodiazepines are not established by this study. Even without a pharmacokinetic interaction, propoxyphene and benzodiazepines share central depressant properties and therefore should be coadministered with suitable caution. A concurrent pharmacokinetic interaction indicates a need for even further caution. Coadministration of propoxyphene and alprazolam, for example, would produce not only the expected pharmacodynamic interaction, but also whatever additional central depressant effect would be produced by the elevated steady-state plasma concentrations of alprazolam due to its impaired clearance.

Caution should also be observed when propoxyphene is prescribed for patients who use alcohol to excess.

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Ativan® for (lorazepam) ℂⓋ Anxiety

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DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

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. . . if you, or a physician you know, have an alcohol or other drug-related problem.

FMA Committee on Impaired Physicians

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, INC
JANUARY 1985, Vol. 72, No. 1

Make early cancer detection a health habit — adopt a low cancer lifestyle

We are winning the War Against Cancer because we treat cancer more effectively, have developed methods to detect it earlier and have increased our knowledge about ways to prevent it. Although we now cure 50% of all cancers, we could markedly increase the cure rate with an increased and more effective use of early detection methods. We also have the opportunity to reduce the incidence of cancer by increasing public knowledge about prevention while stimulating and strengthening individual motivation to change lifestyles when necessary. The primary care physician has the optimal opportunity to make early detection methods a health habit of his patients and is the one best able to motivate his patients to make lifestyle changes needed to prevent or diminish the risk of cancer. The accompanying articles are a plea and a challenge to all who partake to become more active participants in the War Against Cancer by adopting their recommendations.

The first article by Dr. Vincent T. DeVita outlines the National Cancer Institute campaign to reduce cancer risk and the role the physician can play in reaching this national goal.

The need for physician participation in the effort to control smoking and thereby diminish the harmful effects of the use of tobacco is presented by Dr. Charles F. Tate Jr.

Dr. Arthur Holleb presents the dietary recommendations adopted by the American Cancer Society that are likely, in the judgment of experts, to provide a means of reducing cancer risk.

The important roles of BSE and mammography in the early detection of breast cancer that make high five year cure rates possible are outlined by Dr. Everett Shocket.

Dr. LaSalle D. Leffall presents the early detection, diagnosis and management of colorectal cancer.

Drs. Denis Cavanagh and William Roberts discuss the use of the Pap smear as part of an annual mini-cancer screening examination.

The lack of knowledge about testicular cancer by young men and the need for knowledge about testicular self-examination in this rare but highly curable cancer is discussed by Drs. Gerald P. Murphy and K. Michael Cummings.

The role of the physical examination in the early detection of childhood cancer and the importance of early emphasis on proper lifestyle is presented by Dr. Albert H. Wilkinson Jr.

We appreciate the opportunity granted by the Editor of *The Journal of the Florida Medical Association* to update our colleagues about the status of the detection of early cancer and the risk factors to be avoided in order to diminish or prevent the occurrence of cancer. Accept this challenge to make early cancer detection methods a health habit of your patients and to produce a cancer free world by informing and motivating your patients to adopt a low risk cancer lifestyle.

Adelante!

Joseph J. Zavertnik, M.D.
Florida Cancer Council
Guest Editor
Miami

We can prevent cancer

Vincent T. DeVita Jr., M.D.

Last year the National Cancer Institute announced its national goal: to reduce the 1980 cancer death rate in this country by one half by the year 2000. This is a reasonable and reachable objective but it will require the dedication and cooperation of all of us in the field of health care. No segment of the medical profession, I believe, will be more important to this effort than the primary care physician.

In June 1983 NCI conducted a Cancer Prevention Awareness Survey using a national probability sample of 1,876 respondents interviewed one time by telephone. In general, the results indicated that myths and misconceptions persist and that perceptions of risk and potential for personal control over cancer risk vary and are often pessimistic.

Only 38% of the population expressed the belief that cancer risk is related to lifestyle. And when asked if they had ever talked to a doctor about ways to reduce their chances of getting cancer, almost 86% said "no." But when asked how likely they would be to follow a doctor's advice on ways to reduce cancer risk, almost two thirds said they would be "very likely."

I think there is a dual message to be drawn from this survey. The first is that our patients need to understand that lifestyle choices are indeed connected to cancer and that individuals have the opportunity and the power to reduce their cancer risks. The second message is that we physicians have credibility with our patients, and they do listen to us, but we are missing the boat if we do not make active attempts to counsel patients about the ways they can reduce their cancer risks.

Last spring, Health and Human Services Secretary Margaret M. Heckler helped us launch our Cancer Prevention Awareness campaign. The first

The Author
VINCENT T. DEVITA JR., M.D.
Dr. DeVita is Director of the National Cancer Institute, Bethesda, Maryland.

phase was designed to reach the public via the media with the message that individuals can reduce their personal risk. Steps listed in the campaign include:

Don't smoke or use tobacco in any form.

Eat foods high in fiber and low in fat.

Include fresh fruits, vegetables, and whole-grain cereals in your daily diet.

Health and safety rules of your workplace should be known and followed.

Avoid unnecessary x-rays.

If you drink alcoholic beverages, do so only in moderation.

Avoid too much sunlight; wear protective clothing; use sunscreens.

A second phase of the campaign, begun last autumn, is directed at high-risk target groups and seeks more involvement from health-care professionals.

The efforts that we physicians can make to teach cancer prevention to our patients must be ongoing and unending. There is no age group that will not benefit and no season that should limit our efforts.

To me, the opportunity to prevent cancer is one of the most exciting challenges ever. It is an opportunity that we can all share.

NCI resource materials • "Quit for Good," the new smoking cessation kit, includes posters, office tent cards, booklet for physicians on helping patients stop and two booklets for patients, "Quit It" and "For Good." Each kit contains materials for 50 patients.

"Clearing the Air: A Guide to Quitting Smoking" offers a variety of approaches to quitting smoking.

"Despejando el Aire: Guia para Dejar de Fumar," Spanish version of "Clearing the Air."

"Good News, Better News, Best News: Cancer Prevention" contains information on cancer risks — tobacco, diet, alcohol, sun exposure — and simple ways individuals can reduce their risks.

"Buenas Noticias, Mejores Noticias, Las Majores Noticias: Prevencion del Cancer." Same booklet as above, in Spanish.

"Lo Que Usted debe Saber Sobre el Cancer" (What You Should Know About Cancer) answers questions about cancer causes, prevention, treatments, and cures, plus glossary.

"Diet, Nutrition, and Cancer Prevention: A Guide to Food Choices" discusses the reasons for increasing fiber and decreasing fat, lists menus and "choose more, choose less" charts.

NCI Statement: Dietary Fiber and Lower Colon Cancer Risk summarizes current data on role of fiber in cancer prevention.

Research summaries on tobacco, nutrition, estrogen, alcohol, and viruses (for the physician). In-depth reports on cause and prevention, symptoms, detection and diagnosis, treatment.

Fact sheets on nine major risk factors and on risks for 23 major cancers by site. Brief overviews for the layperson. (Also in press as a book, Cancer Rates and Risks, 3rd edition).

Resource Directory lists organizations that conduct smoking cessation clinics, other information of interest to patients.

All are available from: Office of Cancer Communications — Department F, National Cancer Institute, Bethesda, Maryland 20205.

For additional materials, ask for the current Publications List.

• Dr. DeVita, Director, National Cancer Institute, Bethesda, MD 20205.

Lung cancer — the case for prevention

Charles F. Tate Jr., M.D.

Regarding the etiology of 85% plus of lung cancer, it is now well established and accepted that cigarette smoking is the culprit and if people stop the incidence drops. So far as treatment is concerned, in spite of billions of dollars in research and treatment protocols, relatively little has been accomplished in the saving of life. The five year cure rate has remained the same for the past 30 years.

Why is this so? Most people believe lung cancer starts as a malignant change in one cell that begins to multiply, a process measured by the doubling rate. This rate varies with the type of cancer. Small cell or oat cell doubles more rapidly than squamous cell.

On the whole, most researchers believe it takes eight to ten years for the malignant cells to multiply enough for the area to be visible on an x-ray, that is approximately 5-10 mm in diameter, containing approximately 1 billion cancer cells each 10 microns in diameter. During this growth period of predetectability, the cancer is spreading to regional or distant lymph nodes or organs and frequently a distant symptom such as back pain or convulsions may be the first warning of something wrong. There are no pain fibres in the lung, thus, no really early warning system. During this previsible phase, sputa cytology may be positive if studied carefully, leading to bronchoscopy and segment by segment irrigation to localize the lesion, a procedure not yet proven practical. This long predetectable phase during which spread of malignant cells is occurring is why our five year cure rate has not changed for the better in the past 30 years.

I know of nothing on the medical horizon to indicate there will be any change in this picture. We have better surgical techniques and better drugs. In oat cell cancer patients are now living two to three

The Author
CHARLES F. TATE JR., M.D.
Dr. Tate is Professor Emeritus — Medicine and Pulmonary Diseases at the University of Miami School of Medicine, Miami.

years whereas they used to last only six months on an average after the diagnosis was made. This is a decided improvement and an area of hope but overall only 8-10% of patients with lung cancers will be alive five years after the diagnosis is made.

Prevention • Regardless of how you look at it, this boils down to only one answer, one approach, if we ever plan to get ahead of this killer, prevention. Everyone by now realizes that cigarette smoking is the culprit in 85% of cases. Developing data suggest that forced smoking from a smoking spouse or in the work place from smoking workers may well turn out to be the etiology of the other 15%. Smoking is preventable. After approximately eight to ten years without smoking, the smoker's high risk for coronary artery disease death tends to drop back to the nonsmoker's risk and emphysema progression drops dramatically almost at once. Thus, there is a triple pay off for stopping smoking.

However, the average physician seems to have a fatalistic outlook regarding this problem and thus does little to truly get his patients to stop. They feel there is no way to beat the tobacco industry so why waste your time.

Many do not feel they have the time to spare mostly due to the previously mentioned attitude. Most physicians do not feel comfortable in taking a hard-line stand on this problem. By tradition physicians have been cautioned against self advertising or getting the public's attention by making public appearances, by debating the issue on radio, or by fighting for legislative changes. They have not had special training in this area and on the whole are very uncomfortable in these situations. Thus, there has been no massive physician led action to do anything in the legislative arena to control this problem.

It is time for a change in attitude and we physicians, above all people, should know this. Why? We are being crucified because we have been apathetic in this area. We are blamed for the high cost of hospitalization. Who has been hurt? We have. We are now shackled with regulation after regulation. Our fees are now frozen and I am fearful this is just the beginning. Let's do some hardheaded thinking. Where do most major health care cost problems come from? We have been told over and over in the medical and lay literature it is lifestyle. Cigarette smoking and alcoholism lead the list by far and away. Time and again during rounds at Jackson Memorial Hospital, a fast screening has revealed that 60-70% of the patients on the medical floors had serious cigarette or alcohol related illnesses, and we are being blamed!

Lung cancer care from diagnosis to death costs on an average probably more than $100,000 per case. This by no means covers the total loss to a family's future. How do physicians really feel when they see the children standing around the bed of a 50-year-old father or mother dying with lung cancer. The terrific emotional wear and strain cause many of us to avoid this type exposure unconsciously as much as we can. Instead of reacting with anger and determination to try and prevent it in the future, we avoid these stresses and rationalize our action by saying there is nothing we can really do.

Approximately 1,000 cigarette related deaths occur every day in this nation at a terrific cost, approximately $90 billion last year. Again who is getting gored for this terrific cost? Wake up, good doctor, we are being blamed!

Of course, once lung cancer has occurred, the cost and tragedy are inevitable. Of course, once a massive coronary occurs, death or intensive care hospitaliztion follows. We cannot stop it.

Coronary bypass surgery, the most prevalent form of major surgery, will go on and the cost of $20 to $40 thousand per case will go on. Emphysema and respiratory failure, the most difficult and expensive problem in the medical intensive care ward, will continue along with many other smoking related illnesses. We must awaken to what is happening and take some aggressive action to prevent it because most of this disease can be prevented. In lung cancer 85% can be prevented. Severe emphysema is relatively rare in a nonsmoker. Cigarette smoking ranks as the largest preventable cause of coronary heart disease. Cigarette smokers double the incidence of coronary heart disease over the nonsmoker. Two-pack a day smokers quadruple the incidence of coronary heart disease and triple the incidence of death over the nonsmoker. From 1965 to 1980 over 3 million premature deaths from heart disease occurred in Americans from cigarette smoking.

What to do • There is plenty we can do. We can join forces and support the American Cancer Society, American Heart Association, and American Lung Association in efforts to control smoking through state legislation this year. These organizations have joined forces in a common goal to control smoking. This is an historic action initiated by the American Cancer Society in 1982. The National Coalition on Smoking or Health in Washington, D.C. with full-time staff and financial support from Cancer, Heart and Lung recommends that all states and local areas establish Coalitions on Smoking or Health to implement legislative action in this field.

We can also talk to the HMOs and other prepay organizations who profit by preventing major illnesses and hospitalizations. We must convince them that it would be tremendously profitable for them to join forces with us to control smoking. We can also talk to big business corporations or health care coalitions and educate them regarding the effect that the use of tobacco products has on the cost of

the health care premium. We must convince them of the importance of getting their employees to stop smoking. When employees stop smoking, the terrific decrease in medical care, loss of time from work, and improvement in employee morale that occur are well documented.

We can and we must accept more responsibility for the education of our own patients. We can and must spend more time and talk more explicitly to our patients regarding this problem. We must convince Congress regarding the etiology of high medical cost. We must raise taxes on cigarettes to pay this bill!

It is time for a change in attitude and aggressive action.

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Nutrition and cancer: recommendations of the American Cancer Society

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ABSTRACT: Early this year the American Cancer Society for the first time made recommendations about nutrition, issuing a special report about the possible relationship between diet and cancer. The report, "Nutrition and Cancer: Cause and Prevention," contains guidelines similar to those issued in 1982 by the National Research Council of the National Academy of Sciences. The Society's guidelines go beyond those of the Academy in two areas: recommending avoidance of obesity and suggesting increased intake of high fiber foods. Together, the seven guidelines represent an approach to diet consistent in general with maintenance of good health and likely, in the judgment of experts, to provide a means of reducing cancer risk. The primary care physician can help disseminate this information to patients and monitor progress in achieving good nutritional habits.

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In most instances exposure to carcinogens takes place 20 to 30 years before a statistically significant increase in cancer can be detected. Only then can it be adduced that the increase may have been caused by exposure to specific carcinogens.

There is now good reason to suspect that dietary habits contribute to human cancer but it is important to understand that interpretation of human population (epidemiologic) and laboratory data is very complex and as yet does not allow clear-cut conclusions. Although associations of dietary patterns with various forms of cancer have been found, this does not necessarily imply causation. Causation is extremely difficult to establish.

In recent years a number of dietary constituents have been found to protect against occurrence of cancers in experimental animals. The diversity and widespread occurrence of these compounds in food suggest that it may be virtually impossible to consume a diet not containing substances that can inhibit carcinogenesis. Recognition of the range of inhibitors in the diet has led to two major lines of investigation currently being pursued. The first is directed toward understanding the impact these inhibitors play in preventing cancer and, second, how protective effects might be enhanced. Foods may have constituents that cause or promote cancer or protect against it.

No concrete dietary advice can be given that will guarantee prevention of any specific human cancer. The American Cancer Society nonetheless believes that there is sufficient inferential information to make a series of interim recommendations about nutrition that, in the judgment of experts, are likely to provide some measure of reducing cancer risk. These recommendations are consistent in general with the maintenance of good health. They are

similar to and largely drawn from background statements previously issued by the American Cancer Society, National Research Council of the National Academy of Sciences, and National Cancer Institute. As new information is obtained from research, the Society's recommendations will be changed accordingly.

Recommendations •*Avoid obesity:* That obese people are at increased risk of certain cancers has been demonstrated by the massive prospective study, Cancer Prevention Study I (CPS I), conducted by the American Cancer Society. This study, conducted over a 12-year period (1960-1972), found a markedly increased incidence of cancers of the uterus, gallbladder, kidney, stomach, colon, and breast associated with obesity. In this study, when data for obese men and women 40% or more overweight were reviewed, women were found to have a 55% greater risk and men a 33% greater risk of cancer than those of normal weight. Experiments in animals had indicated earlier that incidence is reduced and life span lengthened by nutritionally adequate diets that maintained close to an ideal weight. For people who are obese, weight reduction may be one way to lower cancer risk.

Cut down on total fat intake: Accumulating evidence from both human population and laboratory studies implies that excessive fat intake increases the chance of developing cancers of the breast, colon, and prostate. Excessive intake of both saturated and unsaturated fats, whether from plant or animal sources, has been found to enhance human cancer growth in some studies. Numerous experimental studies have shown that high fat diets increase the incidence of breast and colon cancer in rats exposed to chemical carcinogens. Americans consume about 40% of total calories as fat. A decrease in the amount of fat to 30% of total calories, on the average, has been suggested in the report of the National Academy of Sciences. For most people, this should mean a simple change in food habits, readily achieved by moderation in consumption of fats, oils, and foods rich in fats — an effective way to reduce total calories.

Eat more high fiber foods such as whole grain cereals, fruits, and vegetables: Fiber is a term covering many food components not readily digested in the human intestinal tract. These substances, abundant in whole grains, fruits, and vegetables, consist largely of complex carbohydrates of diverse chemical composition. Agreement on fiber's role in cancer prevention is not universal. Proponents cite a large body of epidemiologic evidence that colon cancer is low in populations who live on a diet of largely unrefined food high in fiber. Other scientists point to epidemiologic data that do not support a preventive role of dietary fiber. They suggest that since refined diets low in fiber are likely to be high in fat, the latter factor may play a more prominent role in elevating cancer risk than a low fiber intake. Even if fiber itself may not prove to have a protective effect against cancer, high fiber-containing fruits, vegetables, and cereals can be recommended as a wholesome substitute for fatty foods.

Include foods rich in vitamins A and C in the daily diet: Dark green and deep yellow vegetables and certain fruits are rich in carotene, a form of vitamin A. Many laboratory tests point to vitamin A (and certain synthetic chemicals related to vitamin A) as reducing the incidence of certain cancers in animals, and a number of human population studies indicate that foods rich in carotene or vitamin A may lower the risk of cancers of the larynx, esophagus, and lung. Examples of foods rich in carotene are carrots, tomatoes, spinach, apricots, peaches, and cantaloupes. Excessive vitamin A in the form of supplements (tablets or capsules) is not recommended because of possible toxicity.

Epidemiologic studies indicate that people whose diets are rich in ascorbic acid (vitamin C), i.e., those consuming diets high in fruits and vegetables, are less likely to get cancer, particularly of the stomach and esophagus. It is still uncertain whether it is vitamin C itself or other constituents of the vitamin C-containing fruits and vegetables that exert the protective effect. Vitamin C can inhibit the formation of carcinogenic nitrosamines in the stomach. The possible role of this inhibition of nitrosamine formation in modifying the incidence of human stomach and esophageal cancer is not known.

Include cruciferous vegetables such as cabbage, broccoli, brussels sprouts, kohlrabi, and cauliflower in the diet: Cruciferous vegetables belong to the mustard family whose plants have flowers with four leaves in the pattern of a cross. Some epidemiologic studies have suggested that consumption of these vegetables may reduce the risk of cancer, particularly of the gastrointestinal and respiratory tracts. Tests in laboratory animals have revealed that the inclusion of cruciferous vegetables in the diet may be highly effective in the prevention of chemically induced cancer. A great deal of experimental work is in progress to determine what components of these foods are protective against cancer.

Be moderate in consumption of alcoholic beverages: Heavy drinkers of alcohol, especially those who are also cigarette smokers, are at unusually high risk for cancers of the oral cavity, larynx and esophagus. Alcohol abuse can result in cirrhosis which may sometimes lead to liver cancer. Epidemiologic studies in Africa, France and China have shown that the consumption of wine and other alcoholic beverages is associated with a high risk of esophageal cancer.

Be moderate in consumption of salt-cured, smoked, and nitrite-cured foods: Conventionally smoked foods such as ham, some varieties of sausage and fish absorb some of the tars that arise from incomplete combustion. These tars contain numerous carcinogens that are similar chemically to the carcinogenic tars in tobacco smoke. The risks may apply primarily to conventionally smoked meats and fish. The food processing industry is now using a "liquid smoke" that is thought to be less hazardous.

There is limited inferential evidence that salt-cured or pickled foods may increase the risk of stomach and esophageal cancer. In parts of the world where nitrate and nitrite are prevalent in food and water, as in Colombia, or where cured and pickled foods are common in the diet, such as in Japan and China, stomach and esophageal cancers are common, and there is good chemical evidence that nitrate and nitrite can enhance nitrosamine formation both in foods and in our digestive tracts. Many nitrosamines are potent carcinogens in animals and may be human carcinogens. Nitrite has been employed traditionally in meat preservation where it acts as a preventive against botulism (food poisoning) and improves the color and flavor of meats. The U.S. Department of Agriculture and the American meat industry already have substantially decreased the amount of nitrite in prepared meats and are searching for improved methods of meat preservation.

Topics of general interest with no specific recommendations • The following substances or dietary practices have received much attention and, therefore, are reviewed but no recommendations are made at this time. All are under investigation.

Food additives: Various chemicals are added to foods to improve color and flavor and to prevent spoilage. Some have been found to cause cancer in animals and have been banned. Others are thought to be protective against carcinogens. Knowledge about the possible cancer risks or benefits of food additives is insufficient to warrant a recommendation for or against their use.

Vitamin E: There is no evidence that vitamin E prevents cancer in humans. While vitamin E is an antioxidant, and antioxidants may prevent some cancers in animals, more research is needed before the role of vitamin E in human cancer prevention can be assessed.

Selenium: Although there is evidence that selenium, a trace element, may offer protection against some cancers, this evidence is much too limited to justify a recommendation that intake be increased. Because of the potential hazard of poisoning, the medically unsupervised use of selenium as a food supplement cannot be recommended.

Artificial sweeteners: At high levels, saccharin has been shown to cause bladder cancer in rats. Epidemiologic studies offer no clear evidence for an increase in risk of bladder cancer among people who are moderate users of this artificial sweetener. Of possible concern is the consumption of saccharin by children and pregnant women. The long-term consequences cannot be predicted from current epidemiologic data. New noncaloric sweeteners are entering the market. Their long-term effects have not yet been studied in humans.

Coffee: Evidence about coffee as a risk factor in human cancer is inconclusive. Although some epidemiologic studies implicate high intake of coffee in bladder and pancreas cancers, others fail to make such a connection. Available information does not suggest a recommendation against its moderate use. There is no indication that caffeine, which is a natural component of both coffee and tea, is a risk factor in human cancer.

Meat and fish cooked at high temperatures such as by frying or broiling: Recent studies have demonstrated that the cooking of meat and fish at high temperatures, such as by frying or broiling, gives rise to a number of potent mutagens (agents that cause genetic changes) in bacteria and some of them have induced cancers in animal tests. This subject is now being investigated in several laboratories.

Cholesterol: Although cholesterol is considered to be a risk factor for heart or blood vessel disease, there is little evidence that a high cholesterol intake or a high cholesterol level also poses the risk of cancer. Evidence relating low blood cholesterol to human cancer in inconclusive.

ACS nutrition research • The Society's extensive research program includes investigations into various aspects of nutrition. The effort has been greatly expanded in recent years, as research findings have indicated a possible protective role of some food substances against cancer. The ACS sponsored its first symposium on nutrition and cancer in 1974. It conducted another national conference on nutrition in 1979 and plans a third for 1985. A workshop conference on nutrition in cancer causation and prevention was held in 1982.

Currently the Society is conducting in-house research and is supporting 24 grants in nutrition research, which together represent committed funds of more than $18 million.

The American Cancer Society's intramural research, a huge multiyear epidemiologic project known as Cancer Prevention Study II (CPS II), is examining the lives, habits, activities, work, and environmental exposures of approximately 1.2 million Americans. Each participant has filled out a detailed personal questionnaire and will be followed by one of 75,000 American Cancer Society volunteer researchers for six years. The current study is patterned after CPS I, which started in 1959 and pro-

duced, among other important data, evidence of the link between cigarette smoking and lung cancer, heart attacks, and other disease that led to the landmark Surgeon General's Report on Smoking and Health in 1964. CPS II asked a number of new questions about cancer and the environment. It is hoped that the study will reveal negative and positive links between diet, nutrition, and cancer. For 1982-1983 its budget was $3.2 million, largely for information processing; its total budget is approximately $9 million.

What the primary care physician can do • The primary care physician is essential to the education of patients about the role nutrition plays in helping to reduce the risk of cancer and in creating and maintaining good health habits.

Physicians may obtain a free copy of the complete Society statement, "Nutrition and Cancer: Cause and Prevention — A Statement of the American Cancer Society," by writing or calling their local American Cancer Society Division or Unit and requesting Professional Education Publication (PEP) number 3389. For the general public, physicians may request "Nutrition, Common Sense and Cancer," also available free from the local ACS; this pamphlet should be ordered by title, quantity desired, and code number — LE 2096.

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Breast self-examination: a patient-physician partnership

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ABSTRACT: Despite the proven diagnostic value of mammographic screening, 75% of breast cancers are still discovered by the patient. This accidental skill can be perfected to discover earlier more curable cancers by a systematic monthly (or oftener) self-examination. Physician or nurse teaching and ongoing physician encouragement can maintain a patient's enthusiasm. Breast self-examination is a patient-physician partnership in health care.

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Breast self-examination is a structured formalization of a process that takes place completely unstructured and quite frighteningly each day, ie, the finding by a woman of a lump in her breast. This year an estimated 86,000 American women (75% of the expected 115,000 cases of breast cancer in the United States) will accidently discover a breast lump which on biopsy will be found to be malignant.

By examining herself on a regular basis, at least monthly, the breast self-examiner has repeatedly demonstrated her ability to detect new lumps some of which are early cancer. Foster's[1] 1973 report from the Vermont Breast Cancer Network Demonstration Project described the malignant tumor mean size for those women practicing BSE (breast self-examination) to be 1.97 cm compared to 3.59 cm for those not practicing BSE. In a subsequent study Foster's group[2] demonstrated improved 5 year survivals, ie, 75% five year survival for those practicing BSE compared to 57% five year survival for those not practicing BSE.

Similarly, Greenwald et al[3] from the Regional Breast Cancer Program for Northeastern New York and Western Massachusetts reported data which on extrapolation predicted a reduced cancer mortality of 18% if BSE was practiced by all women in the United States. The figures from the Brooklyn Breast Cancer Demonstration Network reflect a 10% decline in five year mortality with BSE.[4] If so effective and so convenient, why has BSE required repetitious public entreaties by the American Cancer Society and by interested physicians, nurses, and public health workers? Why are women reluctant to initiate and to practice BSE?

In Gallup polls of public attitudes, practices and understanding in 1973, 1976, and 1983, the incidence of BSE practice was 18%, 24% and 25% respectively.[5,6]

Interestingly the same polls revealed that 95% of the women were aware of the procedure and over 77% of those interviewed said it was of value. Of those not practicing BSE most (74%) said that they did not think they could detect a problem. Half simply preferred to rely on their doctor and their visits to him. Those least likely to practice BSE were women under 29 years of age and women over 50 years of age. Baines,[7] a University of Toronto statistician, crisply focuses on the reason. There are women who dislike touching their breasts. There is the anxiety that comes from feeling any lump in the body, the haunting fear of finding a cancer, and the overwhelming fear of breast amputation. These fears demand physician respect and compassion when teaching BSE.

BSE is well practiced and pursued on a repetitive basis by women when there is a conscientious physician involved in the teaching and when there is sympathetic periodic reenforcement.[7] The physician's commitment to BSE and his use of each periodic breast examination as an opportunity to review with the patient the self-examination technique makes BSE work. His professional breast examination should include inquiry as to how the patient is practicing BSE, when she is doing it, and what her findings have been. The physician should familiarize the patient with her own breast topography by placing her hand over whatever thickening he may feel. The patient-physician partnership concept of BSE is thus enhanced. They are sharing information. Treating the patient as a partner diminishes fear and encourages effective BSE.

Technique • BSE technique requires the use of the patient's flattened fingers, using the pads not the fingertips, in sequential examination of each breast. It is best done lying down, using the right hand for the left breast; the left hand for the right breast. Overlapping circular motions either radially from 12:00 o'clock near the clavicle toward the nipple and from 1:00 o'clock at the periphery of the breast toward the nipple, etc., in the manner of Baines,[7] or transversely from one side to the other, in the manner of Haagensen,[8] or circularly as outlined in the brochure (Fig. 1) of the American Cancer Society.[9] Fingers lubricated with soap move more easily. Crucial is the monthly repetition, after the menses when the breast is least congested or by the calendar once the patient is postmenopausal. Crucial, too, is repetition using the same method always, whichever is selected. Lying down reduces the volume of breast tissue between the skin and the chest wall. As in all effective physician extender programs, there needs to be ongoing dialogue between the responsible physician and the physician extender in the field. BSE works exactly that way. The physician is first a teacher and, then, the available approachable consultant.



Fig. 1. — Booklets on breast cancer, mammography and the technique of BSE available to any patient or professional, gratis, from their county unit, American Cancer Society.

Diagnostic x-ray • Has the dramatic diagnostic x-ray breakthrough changed the need for BSE? In 27 Breast Cancer Detection Demonstration Projects funded by the National Cancer Institute and the American Cancer Society, 280,000 volunteers were screened between 1973 and 1977. Forty four percent of the cancers were found as the result of a suspicious mammogram only. Twenty six percent of the cancers were either noninfiltrating or were infiltrating but less than 1 cm in diameter. Many were not even palpable clinically.[10] Clearly, in the best of all hi-tech worlds every patient vulnerable to breast cancer, i.e., all women over age 40, would have a periodic (annual or bienneal) mammogram. Indeed, the American Cancer Society guideline is precisely that, i.e., a mammogram every year after age 50 (the most vulnerable years); a mammogram every year or two between age 40 and 50 and a baseline mammogram between age 35 and 40. Such screening if applied universally to every American woman would permit almost every cancer of the breast to be found before it is palpable, preferably before it is larger than 0.5 cm. Such malignancies carry a 98% five year survival.[11]

Yet in the recent American College of Surgeon's survey involving 12,315 cases of breast cancer treated in 582 hospitals, each sophisticated enough to have an American College of Surgeon's approved cancer program, only 4% of those 12,315 cancers were found by mammography alone. Seventy three percent were found by the patient's themselves.[12] Why is mammography not finding more cancers in these hospitals? Is it under used?

Mammography may be inappropriately under used because of the expense, publicized risk of radiation, or physician or patient torpor. Regarding the

publicized radiation risk, the National Research Council estimates that the current 1 rad mammographic exposure over a lifetime could potentially induce six breast cancers per year per one million persons so exposed, but at the same time would detect (and potentially cure) 1,000 breast cancers in the same million people.[13] Mammographic techniques have been skillfully honed and the radiation doses dramatically reduced since the pioneer days of Gershon-Cohen, Le Borgne and Egan. Alternative technology such as sonography, thermography and diaphanography (transillumination) are currently being explored as nonradiation alternatives for the early diagnosis of breast cancer. At this writing they remain important interesting tools, but experimental. For instance, Sickles[14] reports that only 58% of cancers can be detected by sonography (ultrasound) and only 8% of those less than 1 cm can be detected sonographically.

BSE is effective when it is initiated by a professional (physician or nurse), facilitated by an illustrative manual or film, and when the patient's enthusiasm is periodically renewed during the course of each professional breast check-up. This sequence ensures effective BSE which cannot but improve breast cancer detection and curability.

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Colorectal cancer

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ABSTRACT: Colorectal cancer is the second most common cancer in the United States. An estimated 130,000 new cases and approximately 59,000 deaths will occur in 1984. Colon cancer is somewhat more frequent in females and rectal cancer slightly more frequent in males. Three tests are important in early detection: digital rectal examination, stool guaiac slide test, and proctosigmoidoscopic examination. To aid in the proper use of these procedures the American Cancer Society has issued these guidelines for the cancer related check-up for colorectal cancer: (1) men and women over 50 should have a stool blood test every year; (2) men and women over 50 should have annual sigmoidoscopic examinations until two consecutive are normal and, thereafter, every three to five years and (3) men and women over 40 should have a digital rectal examination every year. Persons who are at a high risk of colorectal cancer should receive more frequent and intensive examinations beginning at an earlier age. This includes persons with familial polyposis, Gardner's syndrome, ulcerative colitis, history of polyps or prior colon cancer, and family history of cancer of the colon or rectum.

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Colorectal cancer is the second most common cancer (excluding skin cancer) in the United States exceeded in incidence and mortality only by lung cancer. In 1984 there will be an estimated 90,000 new cases of colon cancer and 40,000 rectal with approximately 59,000 deaths. The disease occurs with almost equal frequency in the sexes although colon cancer is somewhat more frequent in females and rectal cancer slightly more frequent in males. Approximately one of 20 American adults will have cancer of the colon and rectum during their lives.

Epidemiology and etiology • Almost all colorectal cancers progress through a polyp (adenoma) phase before they become malignant. These adenomas range in diameter from several millimeters to several centimeters. The evidence in support of the colorectal adenoma-carcinoma sequence is as follows: (1) one third of operative specimens of colon cancer have at least one adenomatous polyp; (2) invasive cancer frequently has been contiguous with adenomatous tissue; in fact, there is a spectrum of change from benign adenomatous tissue to dysplasia or atypia to focal cancer to invasive cancer; (3) the growth of adenomas is characterized by increasing cellular atypia and increasingly abnormal chromosomal patterns similar to those seen in invasive cancer; (4) the many adenomatous polyps that characterize familial polyposis, a well-recognized premalignant state, histologically are similar to adenomas that occur as individual lesions; (5) patients who refuse polypectomy usually develop cancer in the polyp, and (6) if cancer was to arise frequently de novo from flat mucosa, the occurrence of small mucosal lesions, ie, 0.5 cm, would be expected to be a more common finding.

That the majority of colorectal cancer patients are over age 40 evidently reflects the unusually long induction time for a cancer to become clinically apparent — perhaps five to ten years or longer. Since it takes so long for an adenoma to develop and then transform into a carcinoma, it is understandable that the incidence of colorectal cancer increases with age. Only a small proportion of adenomas develops into cancer but the presence of an adenoma puts a patient at increased risk for colorectal cancer. The removal of adenomas detected by sigmoidoscopy sharply reduces the incidence of rectosigmoid cancer in the examined bowel.

The cause of colorectal cancer is unknown but three predisposing factors are genetics, environmental toxins, and diet. Colorectal cancer may be related to genetics but the inheritance of this mutational phenomenon remains to be demonstrated. Nevertheless, colorectal cancer occurs three times more often among first-degree relatives, ie, children, parents and siblings, of persons with the disease than it does in the general population. Inherited adenoma-forming diseases known to put persons at increased risk for colorectal cancer include: (1) familial polyposis syndromes including familial polyposis; Gardner's syndrome; Peutz-Jeghers syndrome, and juvenile polyposis, (2) nonpolyposis inherited colorectal cancer including site-specific colorectal cancer, and cancer family syndrome. When adding the number of colorectal cancers associated with these inherited conditions, the sum amounts to only 10-20% of the total. Suspected but not proven environmental toxins associated with colorectal cancer include machinist's cutting oils, smoke, asbestos, woodworker's glue, carpet dust and crop protection agents. Most of the current evidence, however, suggests that colorectal cancer may be attributable to a dietary imbalance specifically a high-fat/low-fiber diet. As with the environmental toxins, the evidence is primarily correlational and, therefore, does not establish a cause and effect relationship.

Since almost all colorectal cancers arise from adenomas, the primary high-risk factor is the presence of an adenoma or adenomas. Histologically, there are three types of colorectal adenomas: tubular adenomas (most common); villous adenomas, and tubulovillous adenomas. The majority (95%) never become malignant, only about 5% actually progress to cancer. Tubular adenomas have a low malignant potential while adenomas with a villous component have the greatest. The probability of adenomas becoming malignant is related directly to their number, size, degree of villous transformation and presence or absence of dysplasia.

Inflammatory bowel disease constitutes about the only nongenetic predisposition to colorectal cancer, although the disease itself may be an inherited condition. Regardless of age, a patient with long-standing ulcerative colitis is five to ten times more likely to have colorectal cancer than the general population; about 35-50% of such patients develop cancer. The longer a patient has colitis and the more extensive it is the greater the cancer risk. If colitis involves only the left side, it must be present for at least 15 years before the cancer risk increases. If colitis involves the entire colon, then it need be present for only seven years to increase the risk of cancer. Onset in childhood has no bearing on risk, except as it relates to the seven or 15 year duration. Regardless of the extent of colitis, however, the risk, once it begins, is the same. Crohn's disease (granulomatous enterocolitis) is considered premalignant especially when age of onset is before 21 years. The magnitude of the risk for colorectal cancer, however, is much less than that associated with ulcerative colitis. As with Gardner's syndrome, there is a low incidence of small bowel adenocarcinoma associated with Crohn's disease.

Clinical findings and diagnosis • The symptoms and signs of colorectal cancer are rectal bleeding, anemia, change in bowel habits and abdominal pain. Rectal bleeding is the principal symptom and tends to be occult and intermittent. Unexplained iron deficiency anemia should raise suspicion about possible colorectal carcinomas or adenomas. Alterations in bowel habits are likely to include flatulence, diarrhea, constipation, decreased stool diameter, and a sensation of incomplete evacuation. A patient's complaint of ill-defined abdominal discomfort, mild cramps, or pain may well be caused by an obstructing colon lesion usually on the left side. When pain is associated with right colon cancer, it usually is a vague sensation that resembles pain caused by gallbladder or peptic ulcer disease.

In addition to routine physical examination and history taking, there are four diagnostic procedures that should be performed on most patients suspected of having colorectal cancer: digital rectal examination, proctosigmoidoscopy (flexible or rigid), barium enema, and colonoscopy. Digital rectal examination was once sufficient to detect 30% of all colorectal lesions but with a proximal redistribution of neoplasia occurring over the past 20 years, it now can detect only about 10% of all such lesions. Similarly, the estimated yield with the standard proctosigmoidoscopic examination has decreased from 75% to about 50%. Barium enema and colonoscopy are complementary and thus aid in determining the presence or absence of synchronous lesions. The use of colonoscopy in patients with colorectal cancer begins preoperatively. Two to five percent of such patients will have synchronous carcinoma elsewhere in the colon and 40% to 50% will concurrently have one or more adenomas. Patients whose obstructive tumor, clinical condition, or incomplete bowel preparation preclude preoperative

total colonoscopy should undergo this procedure within three to six months after operation. The high risk of subsequent metachronous carcinoma (3% to 5%) and adenoma (10% to 30%) in these patients has led many clinicians to adopt annual total colonoscopy as the primary means of intraluminal surveillance. However the adequately performed barium enema with air contrast in a well prepared colon remains of value in diagnosis and follow-up and may be used to complement colonoscopy with colonoscopy and barium enema alternating on an annual basis. If either is unsatisfactory, the other should be performed.

Screening and survival • Preliminary results of screening for colorectal cancer appear promising. However, there are insufficient data now available to know if the use of the stool blood test can decrease mortality. Clinical trials are now underway and their early results are expected in four to five years. Because of the limitations of the test and the intermittent nature of bleeding from colorectal cancer or adenomas, all persons over 50 years of age should be regularly followed in the health care system regardless of the outcome of the stool blood test. The following tests are important in the early detection of colorectal cancer: digital rectal examination, stool guaiac slide test, and proctosigmoidoscopic examination (rigid or flexible). The fecal occult blood test will detect 90% of all patients screened who actually have colorectal lesions that bleed. It is a relatively sensitive and specific test with acceptable false negative and false positive rates when used appropriately.

The use of commerically available guaiac impregnated slides is a simple, inexpensive and esthetically acceptable method of testing the feces for blood. Patients are asked to prepare at home six stool slides from three consecutive daily bowel movements (two slides per day). To increase the accuracy and discriminating ability of the stool analysis, Greegor believes that a special meat-free, high-residue diet should be implemented at least 24 hours before the first stool specimen is collected and then during the next three days. The diet should contain (a) no meat, fish or chicken; (b) plenty of vegetables — both raw and cooked, especially lettuce, spinach and corn; (c) plenty of fruit, especially prunes, grapes, plums and apples, and (d) bran for the daily cereal. Iron and aspirin should be avoided because they may cause gastric irritation yielding false positive results while vitamin C can interfere with the preoxidase reaction causing false negative results. Fecal occult blood testing is done without hydration to decrease the incidence of false positive reactions. Preliminary data obtained from various centers around the country indicate an apparent definite advantage of fecal blood screening to detect asymptomatic polyps and cancers. Preliminary results of Winawer and his associates include: (1) rate of positive slides of 1-4%; (2) predictive value for neoplasia of 44-50%; (3) favorable Dukes' staging of cancer in the study group, and (4) high patient compliance.

To aid in the proper use of these procedures the American Cancer Society has issued these guidelines for the cancer related check-up for colorectal cancer: (1) men and women over 50 should have a stool blood test every year; (2) men and women over 50 should have annual sigmoidoscopic examinations until two consecutive examinations are normal, and, thereafter, every three to five years, and (3) men and women over 40 should have a digital rectal examination every year. Persons who are at high risk of developing colorectal cancer should receive more frequent and intensive examinations, beginning at an earlier age. This includes persons with familial polyposis, Gardner's syndrome, ulcerative colitis, a history of polyps or prior colon cancer and a family history of colorectal cancer.

Approximately 55% of patients with colorectal cancer have lymph node or distant metastases at the time of diagnosis. The relatively low five-year survival rate of 45% is primarily related to late diagnosis. Therefore, prevention and early detection are important. The two major areas of interest in prevention are: effect of polypectomy for all polyps seen at endoscopy, and role of decreased fat and increased fiber in the diet.

Screening is done to detect colorectal cancer in its earliest stages. As expected the five year survival is directly related to the stages according to Dukes' classification: (a) Dukes A, 70-80%, (b) Dukes B, 50-60%, and (c) Dukes C, 30-40%. Although advances have been made in the diagnosis and management of colorectal cancer, the five and ten year survival rates have improved only slightly over the past 30 years. Whereas 75% of all patients with the disease could be saved if it were detected at an early stage, only 45% currently survive for five years.

Carcinoembryonic antigen • Carcinoembryonic antigen (CEA), a glycoprotein located on the surface of the carcinoma cell, has proved to be disappointing as a screening test for colorectal cancer. In most studies of patients with localized disease, between 30% and 60% have increased levels, whereas positivity approaches 100% when dissemination occurs. A small group of patients with widely disseminated, poorly differentiated adenocarcinoma fails to demonstrate raised levels which suggests that poorly differentiated lesions do not produce CEA. False positive levels have been demonstrated among smokers and those with other gastrointestinal cancer, uterine cancer, lung cancer, lymphoma, carcinoma of the oropharynx, and inflammatory bowel disease. Although its value as a diagnostic screening test is limited, a CEA determination is the most accurate test available

for early detection of metastatic disease after apparently curative resection of colorectal carcinoma. An elevated preoperative CEA level that does not revert to normal postoperatively is highly suggestive of residual cancer. Although many patients with localized colorectal cancer have normal preoperative serum levels, those that do not have elevated preoperative levels have an increased incidence (approximately 2:1) of subsequent recurrence. Serial CEA determinations are done every two months for three years and any rise above normal is investigated thoroughly. Lower CEA levels, shorter interval between detection and operation, and a slow rate of elevation increase resectability. Thus, exploratory laparotomy is recommended for a rising CEA even in the face of a negative work-up. Postoperative elevation of the CEA levels appears to be more accurate than clinical examination, alkaline phosphatase, or any other screening test in the early detection of recurrence and precedes symptoms from the recurrence by months. Unfortunately second-look procedures for metastatic disease yield few cures. Recurrent disease at second-look procedures has been documented in 90% of patients with postoperative elevation of CEA. The predictability of finding recurrent disease relates to the level of CEA. Resectable recurrent disease is more likely with lower elevations of CEA. The speed of elevation of CEA level related to the date of operation seems to be more important: a rapid rise suggests metastatic disease, whereas a more delayed elevation suggests a local recurrence.

Management • Surgical resection remains the treatment of choice in colorectal cancer. An adequate cancer operation involves removal of the primary tumor and wide excision of the mesentery with its contained regional lymph nodes and lymphovascular pathways. Two technical features are important: ligation of the lumen proximal and distal to the lesion to prevent intraluminal spread during the course of operative manipulation, and ligation of the lymphovascular bundles at the base of the mesentery to prevent systemic spread along these routes.

Radiation therapy and chemotherapy may be used also, especially for rectal neoplasms. For those patients in whom a diagnosis of colorectal cancer is established, the optimal goal is to effect cure. The preoperative evaluation includes a general medical work-up, blood tests including carcinoembryonic antigen, chest radiography, intravenous pyelography and liver scan, if indicated. The abdomen should be explored to determine the extent of intraabdominal spread. Mechanical cleansing of the bowel is necessary to reduce infection and can be accomplished by laxatives, enemas and a clear-liquid diet for two to three days preoperatively. On occasion, preoperative parenteral nutrition may be indicated to restore adequate nutrition in patients who are depleted such as those with active inflammatory bowel disease. It is desirable to administer intravenous antibiotics one to two hours preoperatively, intraoperatively and 24-48 hours postoperatively to decrease infection.

Continuing medical education • To increase early detection of colorectal cancer, Health Learning Systems, Inc. (800-526-6312) has developed and produced a national accredited continuing medical education course entitled "Colorectal Cancer: Essentials For Primary Care Physicians." The complete course was designed by an independent faculty of experts in gastrointestinal and family medicine. Sponsored by the Memorial Sloan Kettering Cancer Center, the course is provided in cooperation with the American Cancer Society, American College of Gastroenterology, American Society for Gastrointestinal Endoscopy, American Society of Colon and Rectal Surgeons, International Workgroup on Colorectal Cancer and the National Cancer Institute. The objective is to elicit maximal involvement of primary care physicians in the early detection, diagnosis, management and follow-up of colorectal cancer.

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Early detection of uterine cancer

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ABSTRACT: Carcinoma of the cervix and its precursors can be detected effectively by routine cytologic screening. However, a patient with an obvious lesion should have a cervical biopsy performed. The perfunctory "annual Pap smear" has fallen into some disrepute; it should be replaced with an annual minicancer screening examination. In this, a woman should have her breasts, reproductive organs, and rectum examined with a Papanicolaou smear being performed at the same time.

The Papanicolaou smear is not a good screening device for endometrial cancer, being positive in only about 50% of cases. Routine endometrial tissue sampling would be the best method but this is not cost effective. A high index of suspicion on the part of the primary physician is essential if the death rate from endometrial cancer is to be reduced, and any woman with perimenopausal or postmenopausal bleeding should have a fractional curettage.

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Cancer of the uterus is a loose term embracing all primary malignancies of the cervix and uterine body. The two most common cancers are those of the uterine cervix and of the endometrium. The cervix and uterine cavity are readily accessible to clinical examination so theoretically early detection of these malignancies should be easy. In addition, both of these cancers are preceded by noninvasive precursor lesions in the majority of cases so their treatment should almost eliminate uterine cancer as a cause of death. However, the problem is to acquaint the patient with the "danger signs" for uterine cancer and primary care physicians with the value and limitations of the Papanicolaou smear as a screening method.

Carcinoma of the cervix • Cytology screening came into full clinical use in the United States after publication of the work of Papanicolaou and Traut[1] in 1941. Precursors of invasive cervical cancer were identified as early as 1886 by Williams.[2] Since then our understanding of the natural history of these precursors has increased remarkably. In the 1960s Richart[3] integrated the many terminologies used to describe these precursors into a single term called cervical intraepithelial neoplasia or CIN. CIN is divided into three categories depending on the severity of the cellular atypia and depth of the epithelium involved. CIN 1 involves ⅓ to ½ the thickness of the epithelium, and was previously called mild dysplasia. CIN 2 involves ½ to ⅔ of the epithelium and was previously called moderate dysplasia. CIN 3 involves essentially the full thickness of the epithelium. This term now encompasses both severe dysplasia and carcinoma in situ which for many years have been known to be prognostically inseparable.

It has been shown that CIN will usually progress from 1 to 2, then 3, and finally to invasive cancer over a relatively long period of time. Although in some patients CIN will regress and in others the degree will remain the same, there is no way to determine at present which will develop progressive disease. In one of our screening studies[4] the modal age for CIN 1 and 2 was 20-29, for CIN 3 it was 30-45 and for invasive cancer over 45, and this age spread for the different grades of CIN is typical. As Richart[5] has pointed out, if patients with CIN are followed with colposcopy and cytology, and not biopsied, the great majority will develop progressive disease. Several studies have supported this by documenting progression from intraepithelial to invasive cancer. The most convincing of these is that of Peterson[6] who followed 127 patients with untreated carcinoma in situ of the cervix and found that in 38% invasive cancer developed within 20 years.

Screening women for carcinoma of the cervix in the United States has resulted in a decrease in incidence rate from 42 per 100,000 women per year in 1948 to 18 per 100,000 per year in 1981.[7] Even so, there will be approximately 16,000 new cases and 7,000 deaths from invasive cervical carcinoma this year.[8] Optimal screening should drastically reduce the number of deaths by detecting cervical cancer at an early and curable stage. However, this will be no small task with approximately 350,000 new cases of CIN expected in this country this year, and this represents a continuing rise in the incidence of preinvasive cervical cancer.

Cervical cancer detection • Vaginal speculum examination is an integral part of the pelvic examination. If no obvious lesion is present, then only a Papanicolaou smear needs to be done. However, if a lesion is present, a biopsy should also be performed. A Papanicolaou smear alone is not adequate in this case, because approximately 15% of patients with invasive carcinoma have a negative Papanicolaou smear. It is essential that all physicians realize that a negative Papanicolaou smear does not completely rule out the presence of cervical cancer, so that patients with abnormal vaginal bleeding are instructed to return for further investigation.

Careful attention to proper technique greatly enhances the value of the Papanicolaou smear as a screening device for cervical cancer. First, any excess mucus is removed from the external os. The entire face of the ectocervix is scraped with a wooden spatula and the specimen spread as thinly as possible on a clean glass slide. A saline moistened cotton-tipped applicator is then passed into the cervical canal and rotated so that a good sample of endocervical cells is collected. The endocervical and ectocervical samples can be placed on the same glass slide. Once made, the smear should be fixed immediately in 95% isopropyl alcohol and a brief clinical history written on the laboratory form. This method of obtaining a Papanicolaou smear should minimize both false positive and false negative results. However, keep in mind that where you send the smears is as important as the technique. The bargain price laboratory is probably not the best laboratory. A reliable certified laboratory is absolutely essential for proper screening. An unsatisfactory smear or a smear devoid of endocervical cells should be promptly repeated.

After the cervix has been visualized and the Papanicolaou smear taken, the cervix should be carefully inspected in good light. If the cervix is clean, Lugol's iodine should be applied and any nonstaining area biopsied (Schiller's test). Alternatively, a 4% to 5% solution of acetic acid (table vinegar) may be applied and any white epithelium biopsied. Next, the cervix should be carefully palpated. The normal nonpregnant cervix feels firm. A nodular or friable cervix should be biopsied and a vigorous endocervical curettage performed. A careful rectovaginal examination is done to evaluate the paracervical tissues and nodularity or induration should prompt further diagnostic investigation.

Any patient with postcoital bleeding, intermenstrual bleeding, or excessively heavy "periods", should be examined with special care. It should be kept in mind that some squamous cancers, and many adenocarcinomas of the cervix, are located entirely in the endocervical canal and so are not visible. Liberal use of endocervical curettage in symptomatic patients will detect many of these occult cancers. Any patient who is persistently symptomatic, even with a cervix which appears normal and a negative Papanicolaou smear, should be referred to a gynecologist.

Any patient with an abnormal Papanicolaou smear should be referred to a gynecologist skilled in colposcopy or to a gynecologic oncologist. A Papanicolaou smear is abnormal if dysplastic or malignant cells are present. It is not sufficient to repeat the smear at a later date. Even if the cells are only mildly dysplastic, the finding of such cells calls for further investigation. However, if the smear shows only inflammatory or reparative changes, in the absence of a gross lesion, it is appropriate to treat specific infections and repeat the smear in two months. If these changes persist in spite of therapy, the patient should have a colposcopic examination. In an area where a competent colposcopist is not available, an examination under anesthesia with cone biopsy and fractional curettage is appropriate.

The Papanicolaou smear is an excellent screening technique for cervical cancer but as already mentioned there is a significant false-negative rate. Adding a colposcopic examination to the Pap smear for routine screening will eliminate the great major-

ity of these false-negatives. Unfortunately, as a screening tool, the colposcope is not practical. Its correct use requires a lot of skill and training so for the occasional performer it is very time-consuming. However, Stafl[9] has developed a technique called cervicography which has many of the advantages of colposcopy but takes a very short period of time and can be performed with minimal training. Cervicography is experimental at the moment but in the future it may prove cost-effective for routine screening. It is emphasized that it should not be used as a substitute for colposcopy in the evaluation of a patient with an abnormal Papanicolaou smear.

How often should Papanicolaou smears be taken? The desirable interval between screening examinations for cervical cancer has become an issue for discussion in this country. In 1980 the American Cancer Society changed its guidelines regarding the use of the Papanicolaou test.[10] Now, instead of urging that all women obtain annual Papanicolaou tests for cervical cancer, it advises that women aged 20 and over and those under 20 who are sexually active have the test at least every three years until age 65 but only after they have had two negative Papanicolaou tests a year apart. Women who are at high risk of developing cervical cancer because of early age at first intercourse, multiple sexual partners or other risk factors[11,12] may need to be tested more frequently. A pelvic examination is recommended every three years from age 20 to 40 and annually thereafter.

It should be stressed that these recommendations are intended to help individual physicians and patients select the best early detection protocol for their personal needs. The Society recognizes that individuals have different personal histories, risk factors, objectives, and budgets, and that no single recommendation is best for everyone. Individual physicians and patients may quite properly choose different early detection protocols.[10]

The new guidelines are based on the rationale that invasive cancer is preceded by dysplasia and carcinoma-in-situ stages that are detectable for years prior to invasive disease. The longest estimate from the Canadian Study by Walton and associates[13] is that it takes 30 years for progression from in situ to invasive carcinoma. Other estimates are shorter but most show a grace period over five years. Although all agree that there is almost always a preinvasive stage, the length of that period is still in dispute.

Gynecologic oncologists in this country believe that there are problems with this approach. Both the American College of Obstetricians and Gynecologists (ACOG) and the Society of Gynecologic Oncologists (SGO) still recommend annual cervical cytologic screening examinations for all women. The data which ACOG presented in its statement of policy on "Periodic Cancer Screening for Women"[14] strongly support this view. In 1984, Sadeghi and associates[15] reported on the cytologic screening of 796,337 sexually active women with an average age of 25.9 years. The CIN prevalence rate was 18.8/1,000 for teenagers and 28.8/1,000 for women 20-24. Thus a good case can be made for the annual Pap smear on the basis of CIN prevalence. Furthermore, the annual "Pap smear visit" gave a woman's physician a chance to screen her for other conditions and afforded an annual opportunity for health education. Unfortunately, there was so much emphasis on the Pap smear that the examination was sometimes limited to this and so fell into disrepute. We believe that a new campaign should be launched, aimed not merely at the detection of cervical cancer but simultaneously at several target areas. All primary care physicians, and especially those who serve the urban or rural poor, should encourage women to come for an annual "minicancer screening examination" to screen clinically for breast, gynecologic and rectal cancer with each patient having a Papanicolaou smear performed as part of the examination. We feel that women should be educated in the value of this annual "minicancer screen". The problem in the past was that the annual Papanicolaou smear was all too often limited to a perfunctory cervical scrape.

Carcinoma of the endometrium • Carcinoma of the endometrium is the most common gynecologic malignancy in this country. Approximately 38,000 new cases will be seen this year and about 3,000 women will die of this disease. Unlike invasive cervical cancer, the incidence rate has increased slightly, probably due to an increase in estrogen usage for postmenopausal symptoms. The physician should not hesitate to prescribe estrogens when they are indicated but should know that exogenous usage is associated with an increased risk of endometrial cancer. This has been well documented by several epidemiologic studies.[16-23] Other women at increased risk for endometrial cancer are those who produce excessive amounts of endogenous estrogens. Women in this category include obese women and premenopausal women who are chronically anovulatory. Diabetes mellitus also predisposes to endometrial carcinoma so the physician should be alert for the development of this type of cancer in patients with a tendency to hyperglycemia.

Cancer detection • The value of routine screening for endometrial cancer is certainly not as well defined as it is in cervical cancer. Indeed the Papanicolaou smear is positive in only about 50% of cases and to increase the accuracy of endometrial sampling several devices have been developed to collect cytologic or tissue samples from the endometrium.

Unfortunately use of these devices in screening asymptomatic women is not cost-effective. Koss and associates[24] found an incidence rate of 1.71 cases of endometrial cancer per 1,000 women years in an asymptomatic population over the age 45 subjected to routine endometrial cytologic sampling. Because of the low yield, patient discomfort, and costs as high as $100 per patient visit,[25] routine sampling of the endometrial cavity in asymptomatic women is not advocated at this time.

Diagnosis • Postmenopausal vaginal bleeding occurs in over 90% of patients with endometrial cancer, and the presence of this mandates complete endometrial tissue sampling to establish a diagnosis. In selected patients this can be done in the office with a variety of devices. In other patients, a dilatation and curettage will be necessary. Indeed, this is mandatory when the office biopsy procedures are negative in the face of postmenopausal bleeding. The depth of the uterine cavity should be measured, the endocervix completely curetted, and only then should the cervix be dilated and endometrial curettage performed. This is called a "fractional" curettage and all diagnostic D & Cs should be done in this way. These steps are essential for the accurate staging of endometrial cancer. The FIGO clinical staging for invasive endometrial carcinoma is shown in Table 1 and this correlates well with patient prognosis.

Table 1. — FIGO Clinical Staging for Invasive Endometrial Carcinoma.

Stage I

The carcinoma is confined to the corpus.
Stage IA — The length of the uterine cavity is 8 cm or less.
Stage IB — The length of the uterine cavity is more than 8 cm.

It is desirable that stage I be subgrouped with regard to histologic type of adenocarcinoma as follows:
G1 — Highly differentiated adenomatous carcinoma.
G2 — Moderately differentiated adenomatous carcinoma with partly solid areas.
G3 — Predominantly solid or entirely undifferentiated carcinoma.

Stage II

The carcinoma has involved the corpus and cervix but has not extended outside the uterus.

Stage III

The carcinoma has extended outside the uterus but not outside the true pelvis.

Stage IV

The carcinoma has extended outside the true pelvis or has obviously involved the mucosa of the bladder or rectum. A bullous edema as such does not permit a case to be allotted to stage IV.
Stage IVA — Spread of the growth to adjacent organs.
Stage IVB — Spread to distant organs.

Patients on exogenous estrogen should be monitored very carefully. All should be offered concomitant progestin therapy and have complete endometrial sampling any time irregular bleeding occurs. Some authorities advocate endometrial sampling prior to beginning estrogen therapy and this is especially appropriate in high risk patients. There are also proponents of periodic routine endometrial sampling on all patients on exogenous estrogen, but the yeild of positive results in this situation is very low.

Precursors of endometrial carcinoma have been identified as they have been in cervical carcinoma. Ruffolo and associates[26] have recently suggested a simple nomenclature to categorize these lesions. The system is analogous to that for CIN in cervical cancer. The designation glandular intraepithelial neoplasia (GIN) is used and is divided into three categories. GIN 1 represents cystic hyperplasia and adenomatous hyperplasia without atypia. Both of these lesions have a relatively low malignant potential and can be observed or treated with progestin. GIN 2 represents adenomatous hyperplasia with moderate atypia and GIN 3 represents adenomatous hyperplasia with severe atypia. Both GIN 2 and GIN 3 lesions have a significant malignant potential. Patients with GIN 2 or 3 lesions should be referred to a gynecologist or to a gynecologic oncologist for further therapy.

At the present time, early detection of endometrial cancer primarily depends on prompt attention to symptomatic patients in the high-risk categories. Routine cytologic sampling of the endometrium is not presently cost-effective but may be so in the near future. Most important, with regard to early diagnosis, is patient education. It is essential that perimenopausal and postmenopausal bleeding is reported to a physician without delay and all cases should be investigated. It is especially important to investigate women over 60 because this group has the highest mortality rate.

Conclusion • It appears evident that before significant progress can be made in the diagnosis of uterine cancer, patient and physician delay must be reduced through cancer education programs. With uterine cancer, the earlier the diagnosis is made, the better are results. As Joseph Malins, a Virginia family practitioner, put it many years ago:

> Better put a strong fence 'round the top of the cliff
> Than an ambulance down in the valley.
> A Fence or an Ambulance. Stanza 7

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Teaching patients about testicular cancer

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ABSTRACT: Although rare, testicular cancer is one of the most common cancers and leading causes of death from malignant disease in young men. It occurs primarily in men 15 to 40 years of age and, when detected early, is one of the most easily cured cancers. Unfortunately, diagnosis is often delayed because of patient ignorance, fear, or misdiagnosis. Physicians should make testicular examination a routine part of all examinations for male patients. If a suspicious mass or swelling is found, the patient should be immediately referred to a urologist for evaluation. Young male patients need to be made more aware of the fact that testicular cancer is common in their age group and that self-examination is a valuable health habit.

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Testicular cancer is rare, accounting for only 1% to 2% of all cancers in males;[1] however, it is one of the most common cancers and among the leading causes of death from malignant disease in young men. In males between 15 and 34 years of age, testicular cancer is the most common type of cancer responsible for 19% of cancers in this age group.[1] Of concern is the fact that the incidence is increasing among white males, especially in the age group 15 to 24.[2] For unknown reasons occurrence is rare among American blacks.[2]

The majority of testicular tumors (95%) arise from the germ cells. There are four major types of germ cell tumors of the testis: seminoma, embryonal carcinoma, teratoma, and choriocarcinoma. Each can occur in pure form or two or more can coexist. It is important to distinguish the different tumors since the type influences treatments selected and prognosis.[3-5] Generally nonseminomatous tumors spread faster than seminomatous tumors. Between 60% and 70% of patients with nonseminomatous tumors have lymph node metastasis at diagnosis. Table 1 gives characteristics of each type.

The exact causes of testicular cancer are not known. The different types suggest the existence of multiple causes. There is an increased incidence in patients with cryptorchid testes not corrected before the age of six years.[2] Other suspected risk factors include a family history of testicular cancer, injury to the genitals, heat exposure, and infection.[2,6-8]

When detected early, testicular cancer is one of the most easily cured cancers.[3-5,9] If treated before spread to the lymph nodes, the cure rate is greater than 90%.[4] Unfortunately about 50% of patients are diagnosed after the tumor has spread beyond the testis to lymph nodes in the abdomen or pelvis or to other

Table 1. — Characteristics of Germ Cell Testicular Tumors.

Tumor Type	Tumor Characteristics
Seminoma	Most common testicular tumor. Accounts for 30% to 40% of all testicular tumors. Slow growing. Sensitive to radiation therapy. Best prognosis.
Embryonal Carcinoma	Grows rapidly and tends to spread early. Accounts for 20% to 25% of all testicular tumors.
Teratoma	Occurs primarily in infants and and young children. Accounts for 5% to 10% of all testicular tumors. Considered benign in adults but should be treated as malignant.
Choriocarcinoma	Rare in its pure form. Accounts for 1% to 3% of all testicular tumors. Not well controlled by treatment. Prognosis is usually poorer than with other types of testicular tumors.
Tumors showing more than one cell type	The coexistence of two or more tumor types is common accounting for 30% to 40% of all testicular tumors. The most common mixture is teratoma and embryonal carcinoma.

solid organs.[4] During the past decade improvements in diagnostic procedures, intensive chemotherapy regimens, and development of multitreatment regimens that combine chemotherapy with surgery have significantly improved the prognosis for patients with advanced disease.[5,10,11] However, the combination therapies used for treatment of advanced disease have more complications and are more debilitating than the treatments for early stage disease. Moreover, despite improvements in therapy, the chances of cure are still greater among patients with minimal disease compared to those with disseminated disease.[12] Thus, early diagnosis of testicular cancer remains an important strategy for reducing morbidity and mortality associated with this disease.

Signs and symptoms • The first sign of testicular cancer is usually a painless hard mass about the size of a pea on the front or side of the testicle.[3] Some patients notice a slight enlargement in the testicle or a change in consistency. Acute pain is not common and when it does occur is usually a late symptom that develops only after the nerves of the tunica albuginia or epididymis have become involved. The majority of patients report symptoms related to the testis prior to diagnosis.[13] However, the mildness of typical early symptoms, combined with ignorance or fear of cancer, often cause patients to delay medical attention until the disease has spread to other parts of the body.[12,13] In addition, diagnosis is sometimes delayed because patients presenting with a testicular mass are initially treated as having epididymitis.[12,13] Ultrasound tests will often differentiate between epididymitis and a testicular tumor and should be obtained whenever any doubt exists.[5]

Because testicular cancer is rare compared with other malignancies, little attention has been given to educating the public about this disease. Anecdotal evidence gathered from case reports and papers dealing with diagnosis and treatment suggest that many young men do not know symptoms of testicular cancer and/or are not aware that testicular cancer can occur in their age group.[12,13,15,16] In a survey of 90 male college students at the University of Vermont, Conklin et al[17] found that 75% had never heard of cancer of the testicle. None knew how to examine their testicles and only one person knew what to palpate for. Cummings et al[18] reported similar findings based on a survey of 266 male graduate and undergraduate students at the State University of New York at Buffalo. Fifty two percent of those surveyed did not know any symptoms of testicular cancer and of those reporting symptoms many gave symptoms unrelated to testicular cancer.

Testicular self-examination • A mass or enlargement can usually be detected by careful palpation of the testes. The individual can help by performing a simple self-examination each month for any small lumps or changes in the size of the testis and by seeking prompt medical attention for any changes in a previously normal testicle. Testicular self-examination (TSE) is best performed using two hands. Each testicle should be examined separately by gently holding it with the fingers of both hands and rolling the testicle between the thumb and fingers as shown in Figure 1. The examination should be done after a warm shower or bath when the scrotal skin is relaxed.

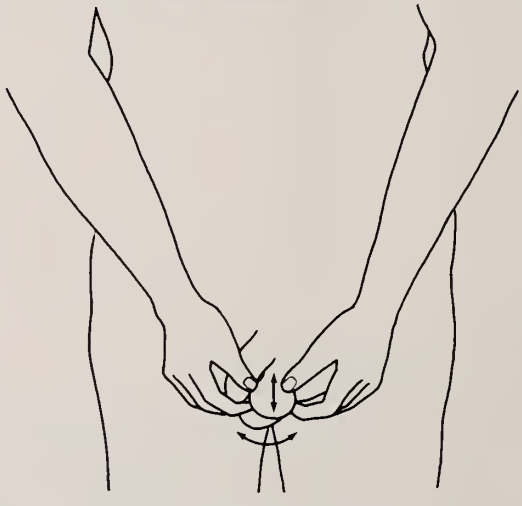


Fig. 1. — Testicular self-examination (TSE).

Self-examination procedures for the early detection of cancer, such as breast self-examination, have been shown to be beneficial and are now widely advocated and accepted. Unfortunately, few men have ever heard about TSE, let alone practice it on a routine basis.[17,18]

Physicians' role in education • Health professionals need to take a more active role in educating their patients about testicular cancer.[12-14] Prevention begins with parents who should have their male infants medically checked to insure that both testicles have descended into the scrotum. About 86% of all testes are descended normally at birth, and most of the remainder will descend within the first year of life.[19] If an undescended testicle is found, it can be surgically brought down into the scrotum. The risk of malignant degeneration of the maldescended testis is reduced if orchidopexy is done prior to the pubescent hormonal surge, preferably before age six.[5] Cryptorchidism is postpubertal patients should be treated by orchiectomy instead of orchiopexy to prevent ipsilateral carcinogenesis.[19] After correction of a maldescended testicle the patient should be followed periodically for early detection of cancer.

Testicular cancer is most easily cured if found early. Physicians should make testicular examination a routine part of all physical examinations of their male patients. Further, if a testicular mass is discovered it should be considered malignant until proven otherwise. Patients with a suspicious mass or swelling should be promptly referred to a urologist. Patients need to be reassured that surgical removal of one testicle does not leave them impotent. Since most young men receive physical examinations for school or employment, doctors and nurses could teach TSE during these visits. In addition, information on testicular cancer and TSE should be included as a part of health and physical education classes at the high school and college levels. Table 2 includes a listing of available educational materials for teaching about testicular cancer and TSE.

In the next several years we can expect fewer deaths from testicular cancer because of improvements in therapy. However, deaths can be further reduced through better education to increase awareness of this disease by patients and physicians, thereby helping to reduce unnecessary delays in diagnosis and treatment.

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Table 2. — Educational Materials on Testicluar Cancer and TSE.

Educational Materials	Descriptions	Where to Write for Materials
Cancer of Testis	A 17-page pamphlet written for the patient with testicular cancer. The pamphlet includes information on the diagnosis and treatment of testicular cancer.	Office of Cancer Communications National Cancer Institute Building 31, Room 10A18 Bethesda, Maryland 20205
Progress in Treatment of Testicular Cancer	A 14-page pamphlet which describes the latest advances in treatment and answers of common questions.	Office of Cancer Communications National Cancer Institute Building 31, Room 10A18 Bethesda, Maryland 20205.
Facts on Testicular Cancer	A 10-page pamphlet which describes testicular cancer risk factors, symptoms, diagnosis and treatment.	Contact you local American Cancer Society office
For Men Only	A 3-page pamphlet which describes how to do testicular self-examination.	Contact your local Amerian Cancer Society office
Testicular Cancer	A 6-page pamphlet which discusses the causes of testicular cancer, symptoms, diagnosis, treatment and prognosis.	Cancer Information Service Roswell Park Memorial Institute 666 Elm Street Buffalo, New York 14263
Testicular Self-Examination	A 3-page pamphlet which explains when and how to do testicular self-examination.	Cancer Information Service Roswell Park Memorial Institute 666 Elm Street Buffalo, New York 14263
Testicular Examination Teaching Kit	Silicone models which can be used to demonstrate normal and malignant testes.	Spenco Medical Corporation P.O. Box 8113 Waco, Texas 76714
Self-Examination of the Testes	A film which teaches testicular self-examination. Available in 16 mm film of ¾ inch video-tape cassette.	Norwich-Eaton Laboratories 17 Easton Avenue Norwich, New York 13815

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Childhood cancer — early detection and prevention

Albert H. Wilkinson Jr., M.D.

ABSTRACT: The second leading cause of death in childhood between ages one and 14 years is cancer. With the multimodal and interdisciplinary approach to the treatment of children with cancer, many have the opportunity for survival tumor free into adult life. Cancer in childhood is vastly different from that in adult life — different in origin, diagnosis, and management. The physician who examines and cares for children must be aware of these differences. Emphasis on the importance of the regular and routine physical examination of children cannot be too strongly placed for this along with early emphasis on proper lifestyles is the most important means for both early detection and prevention.

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The past quarter century has been a period of dramatic changes in the diagnosis and management of cancer in the years of childhood. While during the 1950s survival in certain solid tumors of children began to improve significantly with refinements of surgical care combined with radiotherapy and chemotherapy, the outlook for children with leukemia, the lymphomas and brain tumors continued to be dismal. Since childhood deaths from infectious diseases have been largely eradicated through the use of immunizations and antibiotics, childhood cancer looms second only to accidents as the leading cause of death in children between one and 14 years of age.

Current Status • Since 1970 remarkable strides have been made not only in the treatment of solid tumors but also in leukemia, Hodgkin's disease and non-Hodgkin's lymphoma. Employing multimodal drug therapy in concert with refinements in radiotherapy, some parents can be told that their child has a 50% plus chance for remission leading ultimately to cure. But to accomplish the optimal results of treatment requires a highly skilled team utilizing a multimodal and interdisciplinary approach. This type of collaboration between specialists must extend to every aspect of patient care from diagnostic procedures through definitive therapy, and it must include psychologic and socioeconomic support for the child and family. Such teams exist in children's hospitals and in some large medical centers. Those of us who practice in Florida are especially fortunate for despite the unusual, peninsular geography of our state there are eight established centers for childhood cancer in Florida — two in Miami at Miami Children's Hospital and the

University of Miami School of Medicine at Jackson Memorial Center, the Shands Teaching Hospital in Gainesville, All Children's Hospital in St. Petersburg, the University of South Florida in Tampa, Sacred Heart Children's Hospital in Pensacola, Jacksonville Wolfson Children's Hospital, and the Orlando Regional Medical Center. It has been well documented that an organized and coordinated treatment program performed by a team of experts in such centers is effective in obtaining optimal success and survival times.[1]

Most common malignancies of childhood • The cancers of childhood are strikingly different from those in adult life. Those most often occurring in childhood are the leukemias, Embryonal tumors and sarcomas while adenocarcinomas and carcinomas comprise the majority of tumors encountered in adult life (Table 1). Except in very rare instances of familial polyposis of the colon and in Peutz-Jeghers syndrome, mucosal cancers of the gastrointestinal tract of children are essentially unknown. Cancers of the breast, lung, prostate, bladder and pancreas of the types seen in adults rarely, if ever, occur in childhood.

Early detection and prevention • Because malignancies in childhood are often on an embryological basis and so different from those encountered in adult life, it logically follows that symptoms are different. Rarely, almost never, is blood in the stool, hematuria or hemoptysis a sign of cancer in childhood. Nothing is so valuable in the early detection of cancer in childhood as the routine physical examination by the physician. The warm careful examining hand of the physician during examination of the abdomen will detect a Wilm's tumor in an infant while it is still contained within its capsule and is a Stage 1. An abnormal appearance of the pupil in an infant may reflect a retinoblastoma. Noting on physical examination the presence of cafe au lait spots may lead to the diagnosis of neurofibromatosis with its increased capacity for development of brain tumors. While hairy nevi do not ordinarily pose a hazard for malignant change in childhood unless they cover a large portion of the trunk, the incidence of malignant change in adult life varies from 2-30%. Such lesions should be excised in childhood. If removed in early childhood, total excision with primary closure can often be accomplished. Small nevi located in areas subject to irritation should likewise be removed in childhood. Any lump persisting without adequate explanation in a baby or child deserves excision and/or biopsy.

Vague symptoms of malaise, fever, not wanting to play, and these symptoms especially coupled with paleness should require careful evaluation by the child's physician. Childhood leukemia reaches its peak incidence at about four years of age. Initial symptoms are often vague.

While frowned upon by some of these days of escalating health care costs, the "routine" chest x-ray will occasionally detect a thoracic neuroblastoma before it has invaded vital structures to produce symptoms.

The physician who cares for children must be aware of familial, hereditary and chromosomal abnormalities known to be associated with an increased incidence of malignancy. Familial polyposis demands early removal of the colon if colon cancer is to be prevented in the pubertal, adolescent or young adult with this disorder. Children with Down's syndrome have an increased potential for leukemia. Children with congenital hemihypertrophy and aniridia display an increased incidence of Wilms tumor. These children should be examined on a regular basis with sonography and intravenous pyelography. Retinoblastoma, neuroblastoma and Wilms tumor can all be inherited.[3]

No discussion of prevention of malignancy in childhood should take place without pointing to the importance of genetic counseling for the couple anticipating developing a family where one or both parents has had a malignancy known to have capacity for inheritance. As more and more children survive into adult life, following cure of their cancer, this problem takes on larger proportion and implications. And as these children survive, the risk of secondary malignancy related to initial modalities of treatment both from chemotherapeutic agents and x-ray must be known to the physician who examines and treats children. Physicians should teach pubertal and adolescent girls breast self examination while boys should periodically feel their testicles for evidence of enlargement.

Table 1. — Relative Frequency of Malignant Neoplasms in the United States, Children Age 1-15 Years.[2]

Histologic category	White		Black	
	Rank Order	% of Total	Rank Order	% of Total
Leukemia	1	33.8	1	24.9
Central nervous system	2	19.2	2	24.4
Lymphoma	3	10.6	3	14.2
Sympathetic nervous system	4	7.7	5	7.1
Soft tissue	5	6.8	7	4.0
Kidney tumors	6	6.3	4	8.0
Bone tumors	7	4.5	6	4.9
Retinoblastoma	8	2.7	8	3.1
Gonadal and germ cell	9	1.8	9	2.7
Liver tumors	10	1.5	10	0.4
Teratoma	11	0.3	11	0.4
Miscellaneous		4.9		5.8

Finally, and in summary, good habits of health and hygiene should commence in childhood. Nutritious diets with avoidance of excesses combined with exercise and clean air may not only serve to curb the rise in heart diseases but also in cancer. We should begin early to educate children about the hazards from smoking, excessive use of alcohol and the potential teratogenic effects of some drugs. Yes, the physician who cares for children has a great and enlarging role to play in the early detection and prevention of childhood cancer for he or she must be especially careful in history taking and physical examination while being knowledgeable about the familial and genetic tendencies of cancer in children.

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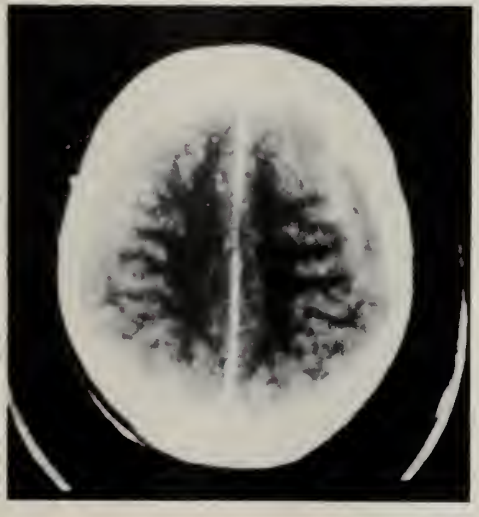
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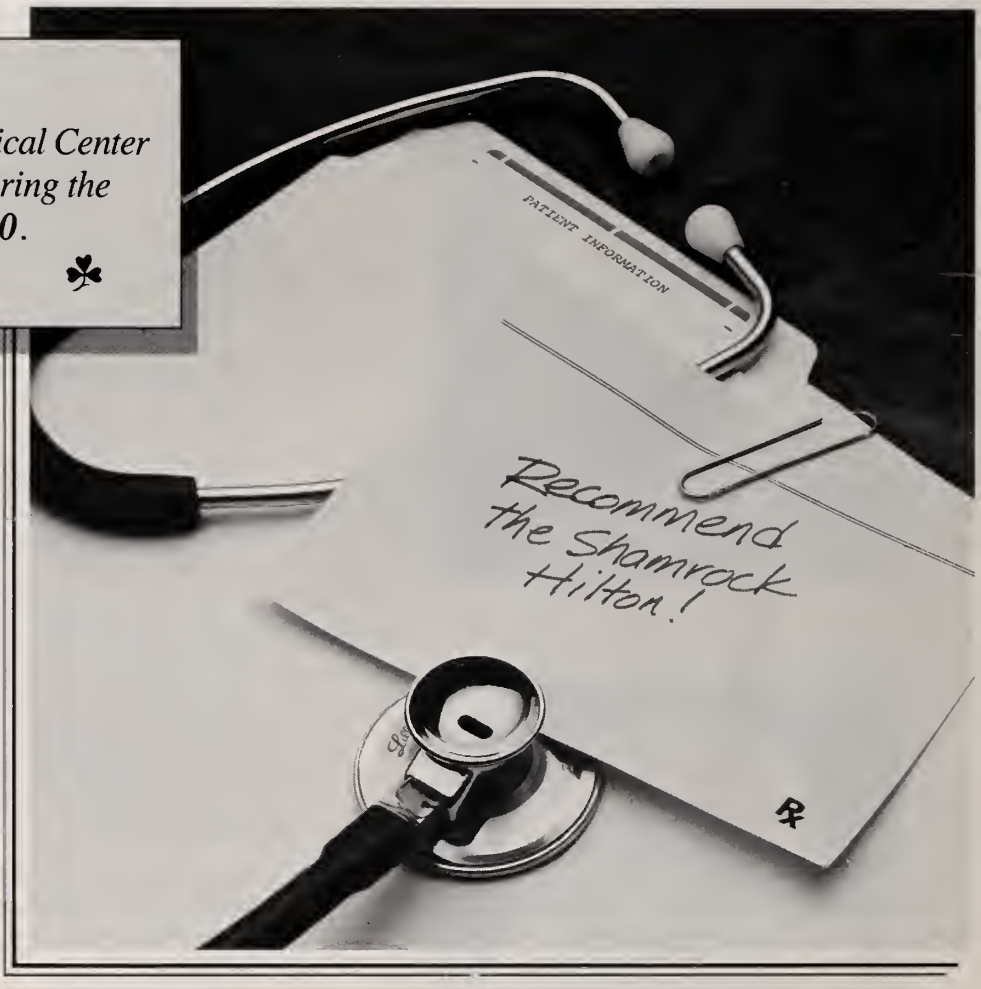
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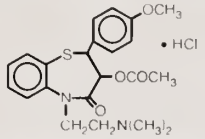
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Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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J-4044 January 1984

HOW A STUDENT WHO COULDN'T LEARN TAUGHT EVERYONE AN IMPORTANT LESSON.

Everyone thought Matthew Francisco was failing school.

But was he really?

You see, Matthew has a learning disability. And no matter what his parents and teachers did, his problem only seemed to worsen. (Matthew even started running away from home to avoid school.)

Finally Matthew's mother, Barbara, did some homework of her own and got in touch with the Minnesota Association for Children and Adults with Learning Disabilities, a United Way supported agency.

The Association helped Barbara deal with Matthew at home and his teachers deal with him at school.

Before long Matthew was solving problems in school instead of just being one.

And through her involvement with The Association, Barbara now schools other parents with learning disabled children.

This is just one of thousands of similar stories from all over the country.

And, as the Franciscos can attest, United Way does a lot in your community.

Everything from day care to foster care to care for the elderly.

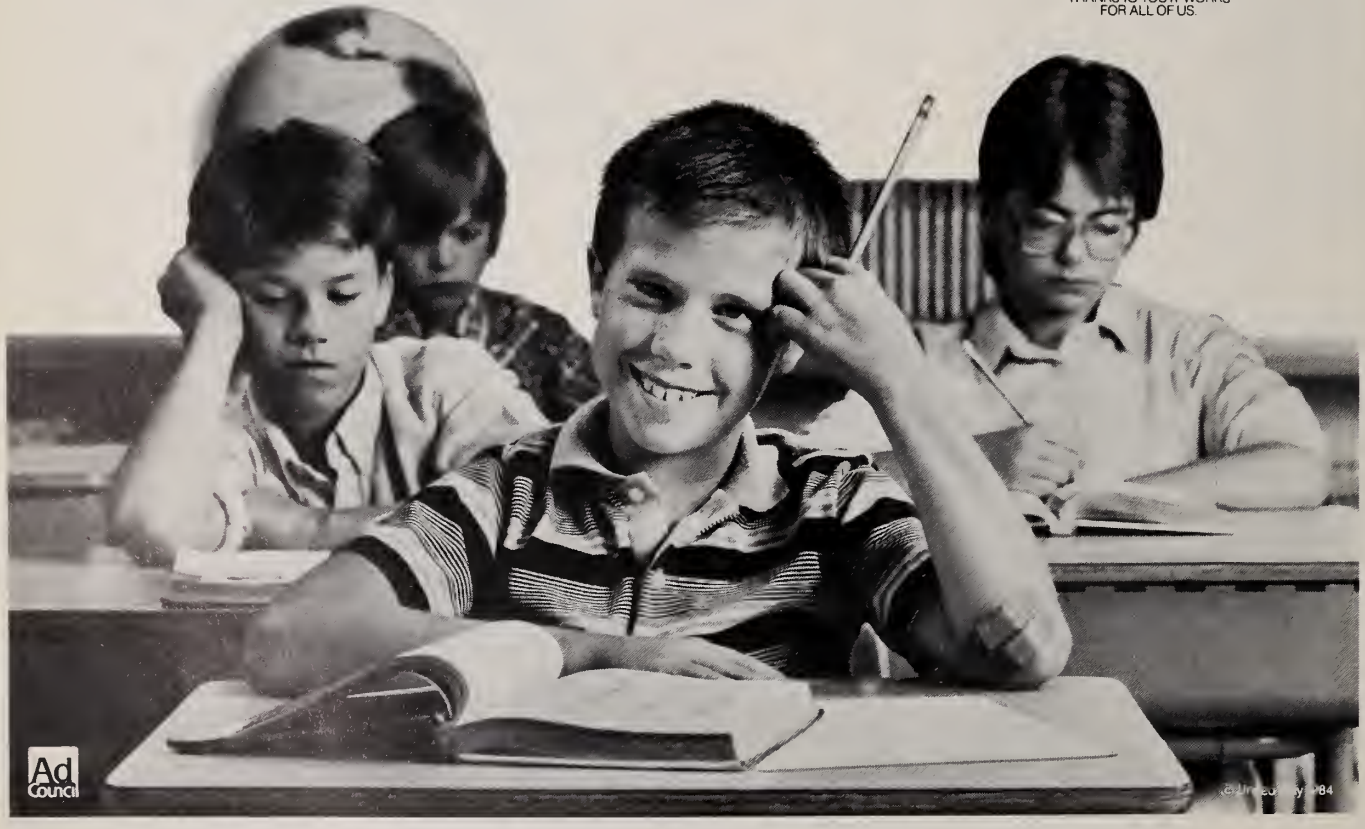
And what makes it all work are generous contributions from people like yourself.

People who realize that without their help, United Way simply cannot exist.

Matthew, his parents and his teachers thank you.

So do we.

United Way
THANKS TO YOU IT WORKS FOR ALL OF US.



FLORIDA MEDICAL

DEPARTMENTS

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NOTES & NEWS

Dr. Mahan receives national award for preterm birth prevention

Florida's Preterm Birth Prevention Program, credited with reducing the state's incidence of low birthweight babies by 11.5% during the past year, has received national attention.



Dr. Mahan

Program Director Dr. Charles Mahan, a professor of obstetrics and gynecology at the University of Florida's Health Center, received the "Healthy Mothers, Healthy Babies Award" during recent ceremonies in Washington, D.C. The presentation was made by C. Everett Koop, M.D., Surgeon General of the U.S. Public Health Service, who praised the Florida program for its scope, efficiency and cost effectiveness in tackling the low birthweight problem.

Low birthweight, defined as under 5.5 pounds, is the leading cause of death and illness among Florida infants, and has been targeted by the Florida Legislature as a No. 1 health priority.

Dr. Mahan is directing the Florida program under auspices of the state's Department of Health and Rehabilitative Services (HRS), with partial support from the March of Dimes Birth Defects Foundation.

Initiated in October 1983, the program has been called one of the most massive statewide health education projects in the nation. Dr. Mahan and HRS employees traveled the state giving intensive seminars to health care providers, using a March of Dimes-developed protocol for identifying high-risk women and counseling them in an effort to prevent premature births. Within a few months, more than 1,500 public health nurses and health department directors had received such training.

Dr. Mahan says the program returns an estimated three dollars for every dollar spent on prenatal care in savings on life support for preterm infants in state-supported neonatal intensive care units. The program is continuing for another four years, with a goal of lowering the state's incidence of preterm births by at least 50%.

UF faculty accept leadership roles in state anesthesiologists' society

Charles P. Gibbs, M.D., Professor of Anesthesiology and of Obstetrics and Gynecology at the University of Florida's College of Medicine, is the newly elected president of the 700-member Florida Society of Anesthesiologists.

The society also has elected Lawrence S. Berman, M.D., an Associate Professor of Anesthesiology and Pediatrics at UF, to serve as second vice president and chairman of the continuing education and special sessions committee.

At the same fall annual meeting at Captiva Island, Jerome Modell, M.D., Professor and Chairman of the Department of Anesthesiology at UF's medical school, was appointed chairman of the society's legislative committee.

Dr. Gibbs, who also is Assistant Dean for curriculum at the UF College of Medicine, has been active in the society for almost 10 years, having served on the board of directors as first vice president and president-elect, and as chairman of the patient care committee for about five years.

A member of UF's medical faculty since 1972, Dr. Gibbs is a graduate of Indiana University School of Medicine at Indianapolis. He also completed residency training in OB/GYN at Indiana University, following which he served as a surgical fellow at the Mayo Clinic, as an NIH Clinical Fellow at the University of Miami School of Medicine, and as an NIH research fellow at the Nuffield Institute for Medical Research in Oxford, England.

Dr. Berman accepted an appointment with UF's medical college in 1978, coming from the Naval Regional Medical Center in Portsmouth, Virginia where he was a staff physician in pediatrics and anesthesiology. He earned his M.D. at Jefferson Medical College in Philadelphia, and finished residency training in pediatrics at Jackson Memorial Hospital at the University of Miami.

Dr. Berman later returned to Philadelphia to complete residency training in anesthesiology at the University of Pennsylvania and a Fellowship at the Children's Hospital there. He served a year as a clinical instructor of pediatrics at Jefferson Medical College in Philadelphia and two years as a staff physician with the Naval Regional Medical Center prior to his UF appointment.

Dr. Bolivar honored posthumously by French government


Dr. Bolivar

The late Juan C. Bolivar, M.D., Professor of Surgery, University of South Florida College of Medicine, was honored posthumously by the French government on December 11, 1984. Philippe Gregoire, Consul General of France, came to Tampa from New Orleans to present the medal of the Legion of Honor, France's highest civilian award, to Dr. Bolivar's family in recognition of his service to that country. Some two hundred friends and colleagues of Dr. Bolivar joined Richard G. Connar, M.D., Chairman of the Department of Surgery, in the ceremony at the medical center.

Palm Beach County Medical Society EVP dies

Michael H. Lopez Jr., executive vice president of the Palm Beach County Medical Society for 14 years, died December 22, 1984 of a massive heart attack. He was 49 years old and lived in Lake Clarke Shores.

Mr. Lopez, who was born on June 27, 1935, in New York, was raised in Miami. He graduated from Gesu High School and the University of Miami. Before coming to West Palm Beach 14 years ago, he served as assistant director of the Dade County Medical Association.

The host of *Call the Doctor* on WPTV-Channel 5 for nine years, Mr. Lopez was also a member of the Economic Council of Palm Beach County, the Forum Club of the Palm Beaches, the School Health Advisory Council, Voluntary Action Council and the Gulfstream Council of the Boy Scouts. He was active in Child Keyppers.

Mr. Lopez was on the board of directors of Crisis Line, the Arthritis Foundation, Goodwill Industries, the Community Action Council, and the Flagler National Bank in Lake Clarke Shores. He was also on the board of trustees of the Leukemia Society.

He is survived by his wife, Cathy; two sons, Michael A. Lopez of Port St. Lucie and John V. Lopez three daughters, Lori-Ann Shirk of Port St. Lucie, Denise Lynn Lopez and Angel Kristen Lopez, both of West Palm Beach; and two grandchildren.

DEAN'S MESSAGE

A revolution

Prior to World War II, the health care delivery system in this country was relatively simple. Fee for service and house calls were expected by patients. Sulfonamides, digitalis, morphine, and belladonna were therapeutic mainstays. The medical advances emanating from World War II were legion. Antibiotics, life support units, and sophisticated blood banking are just a few. Medical research became a major national priority with the formation of the National Institutes of Health in 1948 and the results of medical research are well known.

With increased technology requiring more and more skilled technicians, costs increased. Professional liability suits and enormous awards have funded the spiraling costs.

There are major movements underway today that may affect health policy in our country. Health maintenance organizations have made enormous strides in captivating the public. Even conservative, mainline insurance companies have entered the HMO market. Investor-owned hospital companies are growing exponentially. Even the teaching hospitals and universities have entered into a variety of arrangements with the investor-owned companies. Nonprofit hospitals have formed a host of multihospital systems. Physicians have entered into a multiplicity of provider organizations which either pay the physician a salary or reimburse the physician on a discounted basis. Store-front ambulatory centers are commonplace. One academic medical center has purchased private practices in their community.

Yes, a revolution exists. Hospitals even advertise! Competition is a byword. No one can predict what the future holds. Clearly, there are many pure entrepreneurs involved in these changes and the consumers of medical care — the patients — are being attracted in large numbers. Some patients are beginning to become disenchanted. Many physicians involved are also severing their relationship.

Physicians need to keep the primary goal of our profession in the forefront of our thoughts — the patient. Each new scheme for an alternative delivery system should be carefully analyzed to determine its benefit or detriment to the patient.

We must be steadfast as all around us changes. At the same time, it is vital that we listen and hear what the public — our patients — are telling us. Basically, they want high quality care at a reasonable cost with the physician-patient relationship preserved. They want access and efficiency.

It is incumbent upon the profession to maintain our equanimity, work with all groups, and keep our mission foremost. After the revolution is over, there is no doubt but that a variety of delivery systems will exist, each serving their own constituency. The only recognizable remnant of the past that will remain will be the most valued characteristic of the profession — the physician-patient relationship.

Our future is our past!

William B. Deal, M.D.
Dean and Associate Vice President
University of Florida
College of Medicine

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

The "fat lady" scam

A popular deception is the so-called "fat lady" scam, perpetrated by an itinerant team of four or five badly overweight women and one man. Their carefully devised plan involves moving to a new community, developing a schedule which allows each female member to visit a maximum number of physicians each day for a week or so.

The "scam" is (with variations) that the patient is very unhappy, due to her chronic weight problem. Her husband is about to leave her, her children are embarrassed, and she professes to be weak and unable to maintain a diet regimen. In desperation (she has considered suicide!) she wants to discuss the possibility of having her jaws wired shut or having part of her intestines removed. The interview is usually tearful and well delivered, and inexorably moves to a consideration of medication as an alternative.

At this point the "professional patients'" skills come into play. PRELUDIN is usually mentioned as the drug of choice — followed in rapid order by other Schedule II AMPHETAMINES. If the physician refuses to prescribe a Schedule II drug, the "professional patient" quickly acknowledges that DIDREX has worked in the past and, of course, suggests that the physician add a couple of refills. At this point the "professional patient" might ask for a prescription for a sleeping pill because it will be difficult to sleep after taking the weight-control drug.

A more daring scammer might also request a tranquilizer, such as VALIUM, so that the other drugs do not make her edgy.

Following a successful scam, the female "professional patient" is allowed to keep only a small number of the pills secured. The majority are sold by her "man" to local street dealers. Weekly profits from the numerous prescriptions obtained by such gangs have been estimated to be as high as $10,000. This figure was confirmed by actual accounting records of several drug dealers arrested for selling controlled drugs.

Reminder • Physicians are reminded that the potential for abuse of stimulant controlled drugs outweighs any benefits derived as a weight control method. Studies consistently indicate that patient weight loss induced by stimulants is usually regained immediately after the patient is removed from the drug. The latest information available from national physicians' associations indicates that behavior modification, dieting and exercise are the only recommended methods to achieve weight loss.

Caution • Physicians who do prescribe stimulants are cautioned to be wary of patients unknown to them (request positive/picture identification), patients who report they have been seeing other doctors, or patients who are enthusiastic about medication taken in the past (usually PRELUDIN). Physicians should also be alert to situations where several such women are seen in a short period of time or when patients report they were referred by other patients with the same medical condition (obesity).

A defense against cancer can be cooked up in your kitchen.



Fruits, vegetables, and whole-grain cereals such as oatmeal, bran and wheat may help lower the risk of colorectal cancer.

Foods high in fats, salt- or nitrite-cured foods like ham, and fish and types of sausages smoked by traditional methods should be eaten in moderation.



There is evidence that diet and cancer are related. Some foods may promote cancer, while others may protect you from it.

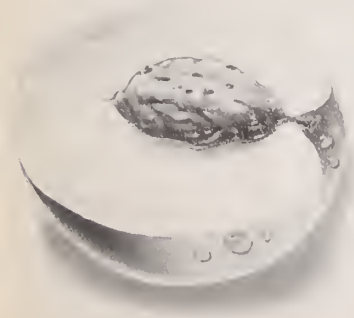
Foods related to lowering the risk of cancer of the larynx and esophagus all have high amounts of carotene, a form of Vitamin A which is in cantaloupes, peaches, broccoli, spinach, all dark green leafy vegetables, sweet potatoes, carrots, pumpkin, winter squash and tomatoes, citrus fruits and brussels sprouts.



Be moderate in consumption of alcohol also.

A good rule of thumb is cut down on fat and don't be fat.

Weight reduction may lower cancer risk. Our 12- year study of nearly a million Americans uncovered high cancer risks particularly among people 40% or more overweight.



Foods that may help reduce the risk of gastrointestinal and respiratory tract cancer are cabbage, broccoli, brussels sprouts, kohlrabi, cauliflower.

Now, more than ever, we know you can cook up your own defense against cancer. So eat healthy and be healthy.

No one faces cancer alone.

AMERICAN CANCER SOCIETY®

Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

Allied health careers recruitment

In order to provide important health services for the nation in years to come, the Auxiliary has made recruitment in health care careers a priority. By providing information, resources for materials, financial support and sponsoring community programs, the Auxiliary has attracted the attention of youths interested in health field careers.

During the second half of this century a new term covering a broad range of health care careers came into public use...ALLIED HEALTH. At its inception the fields of nursing and medical technology ranked high on the "needs" list, but in recent years this status has been relinquished to other health care employment areas, such as physical and occupational therapy, speech pathology, biomedical research, and medical office management. The physician also is becoming more dependent on the assistance of allied health personnel in order to meet the manpower needs brought about by the emergence of new, highly specialized health care services, not only in the hospital, but also in other vital settings, such as outpatient facilities, nursing homes, rehabilitation centers, and extended care institutions.

In the past most medical care was given in hospitals where "on site" training was provided. Today, with the shift of care to other facilities, personnel are needed who are trained in the new procedures and facilities. The *Occupational Outlook Handbook*, printed by the U.S. Bureau of Labor Statistics, states that the health care field is expected to continue its rapid growth in the 1990s due to the greater awareness of the importance of health care, a growing — as well as older — population, increasing expenditures by governments and insurance companies, and the demands of the consumers.

The AMA Auxiliary publishes a booklet entitled, *Health Manpower Package Program*, which outlines in detail suggested methods to promote allied health care careers recruitment. The FMA-A, through its Health Careers Chairman, promotes recruitment with scholarships, workshops, and Health Occupation Students of America, (HOSA) — a national organization formed in 1976 to bring together students interested in becoming future health care personnel of America. The Florida chapter of HOSA is one of 32 organizations which collectively have over 32,000 members under the auspices of State Boards of Vocational Education and Health Occupation Education. Local chapters provide programs and activities to help students develop their physical, mental, and social well-being, as well as fostering leadership and occupational skills in the allied health careers.

The FMA-A is working to bring about community awareness of the Auxiliary's goals to promote good health for all and recruit health care personnel. Workshops are sponsored for junior and senior high school students, teachers, occupational specialists, and others. Financial support through HOSA is provided by the Auxiliary in the form of a scholarship award to the outstanding Florida HOSA student. The Auxiliary will also sponsor one of the competitive events at the 1985 meeting of HOSA. County auxiliaries are urged to support local HOSA chapters by contributions and professional membership in HOSA, and are encouraged to examine or begin their own programs for recruiting allied health care personnel.

"The Hands of HOSA Mold the Health of Tomorrow"

Mrs. Margaret (Ferdinando) Vizzi
State Health Careers Chairman
Tampa

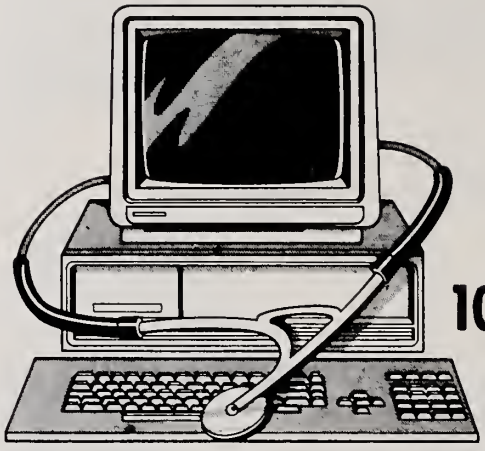


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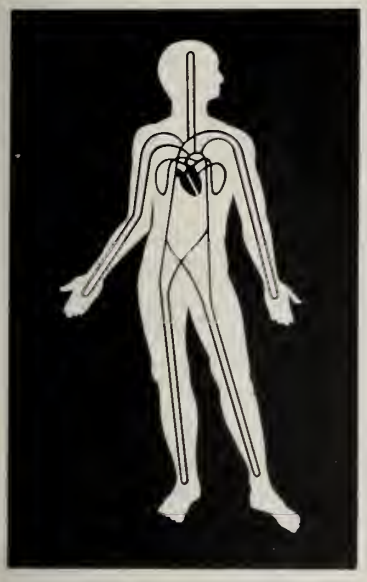
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Winter-Summer 1985 Seminar Schedule

In Florida:			
Lake Buena Vista, Florida	**January**	**25-27**	**Hilton Hotel**
Ft. Lauderdale, Florida	**March**	**22-24**	**Bahia Mar Hotel**
Kissimmee, Florida	**July**	**26-28**	**Orlando Hyatt Hotel**
Other States:			
Las Vegas, Nevada	January	25-27	MGM Grand Hotel
Scottsdale, Arizona	February	8-10	Doubletree Inn
Palm Springs, California	February	15-17	International Hotel Resort
New Orleans, Louisiana	February	22-24	Hyatt Regency Hotel
Maui, Hawaii *	March	25-29	Sheraton Hotel
Las Vegas, Nevada	March	29-31	Desert Inn Hotel
Williamsburg, Virginia	April	19-21	Hospitality House
San Francisco, California	April	26-28	Renaissance Hotel
Washington, D.C.	May	3-5	Marriott Hotel
Newport Beach, California	June	21-23	Balboa Bay Club
Toronto, Canada	June	21-23	Inn on the Park
Hilton Head, South Carolina	July	19-21	Mariners Inn
Anaheim, California	August	2-4	Disneyland Hotel
Cape Cod, Massachusetts	August	9-11	Dunfey Hyannis Hotel
Monterey, California	August	16-18	Doubletree Inn

* Maui, Hawaii - Special 16 hour program

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Meetings

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

FEBRUARY

11th Annual Conference in Anesthesiology, Feb. 2-9, Vail Colorado. For info.: Sonja Craythorne, Department of Anesthesiology, Post Office Box 016960, Miami 33101, (305) 547-6411.

Current Concepts in Pain Management, Feb. 4-8, Steamboat Springs, CO. For information: Dr. Berman, 3301 Johnson St., Hollywood 33021, (305) 989-6650.

19th Annual Symposium on Cosmetic Surgery, Feb. 7-9, Miami. For information: 233 N. Michigan Avenue, Suite 1900, Chicago, IL 60601.

Ophthalmology: Clinical Update, Feb. 7-9, Hyatt Regency Grand Cypress, Orlando. For information: Phil Pyster, 2020 West Fairbanks Ave., Winter Park 32789, (305) 647-8839.

Conference on General Pediatrics, February 7-10, Ft. Lauderdale Marriott Hotel and Marina. For information: Ellio Ellis, M.D., Children's Hospital of Buffalo, 219 Bryant Street, Buffalo, NY 14222, (716) 878-7630.

Update Anesthesia 1985, Feb. 9-10, Holmes Regional Medical Center. For infor.: George Mix, M.D., 1304 S. Oak Street, Melbourne 32901.

Timely Topics in Obstetrics & Gynecology with Duke Univ., Feb. 11-13, The Good Samaritan Hospital, W. Palm Bch. For info.: Barbara L. Breznen, P.O. Box 3166, West Palm Beach 33402-3166, (305) 655-5511.

Miami Wintercourse Symposium, Advances in Gene Technology, Feb. 11-15, Miami. For info.: Sandra Black, Dept. of Biochemistry & Papanicolaou Institute, P.O. Box 016960, Miami 33101, (305) 547-6265.

Current Concepts in Ophthalmology, Feb. 11-16, Bahia Mar Hotel, Ft. Lauderdale. For information: Phil Pyster, 2020 W. Fairbanks Avenue, Winter Park 32789, (305) 647-8839.

OB/GYN Ultrasound and Perinatology Symposium, Feb. 15-19, Miami Bch. For information: Dept. of OB/GYN, Patti Mundy, P.O. Box 016960, Miami 33101, (305) 547-6944.

February Course in Arrhythmias, Feb. 18-20, Marriott Harbor Beach Hotel, Ft. Lauderdale. For information: Jules Constant, M.D., Cardiac Study Fund, P.O. Box 114, Hiler Brand, Buffalo, NY 14223, (716) 836-5172.

Conference on the Beach, Feb. 19-23, Daytona Hilton, Daytona. For info.: Bernard Breiter, M.D., P.O. Box 1990, Daytona Beach 32015, (904) 254-4167.

OB/GYN Caribbean Seminar, Feb. 20-24, Miami Bch. For information: Dept. of OB/GYN, Patti Mundy, P.O. Box 016960, Miami 33101, (305) 547-6944.

Breast Cancer Update International 1985, February 21-23, Biscayne Marriott Hotel, Key Biscayne. For info.: Dan Osman, M.D., 6614 Miami Lakes Drive E, Miami Lakes 33014, (305) 687-1367.

XII Pediatric Dermatology Seminar, Feb. 21-24, Doral Beach Hotel, Miami Bch. For information: Guinter Kahn, M.D., 16800 NW 2nd Avenue, Suite 401, N. Miami Bch. 33169, (305) 652-8600.

The Diagnosis and Management of the MII, Feb. 22-24, Marriott Hotel, Ft. Lauderdale. For info.: Beverly Jacobsen, 64 Inverness Dr. E, Englewood, CO 80112, (303) 790-8445.

The Acute MI, February 22-24, Ft. Lauderdale. For info.: Margaret Kleiger, 64 Inverness Dr. E., Englewood, CO 80112, (303) 790-8445.

5th International Symposium on Neurological Surgery of the Ear and Skull Base, Feb. 23-28, Sarasota. For info.: Beryl E. Adams, SCMS, 1845 Hillview St., Sarasota 33579, (813) 366-2700.

Winter Conference on Principles of Practice Management, Feb. 23-Mar. 2, Vail, CO. For info.: Dept. of Anesthesiology, Sonja Craythorne, P.O. Box 016960, Miami 33101, (305) 547-6411.

Intensive Care Symposium, Feb. 23-Mar. 2, Vail, CO. For info.: Dept. of Anesthesiology, Sonja Craythorne, Post Office Box 016960, Miami 33101, (305) 547-6411.

Pediatric Dermatology Seminar XII, Feb. 24-25, Doral Bch. Hotel, Miami Beach. For information: Guinter Kahn, M.D., 16800 N.W. 2nd Avenue, Suite 401, Miami 33169, (305) 652-8600.

Persistent Renal - GU Disorders, Feb. 24-28, Bal Harbour. For information: Dept. of Pediatrics, Pearl Seidler, P.O. Box 016960, Miami 33101, (305) 549-6726.

Probing Pediatric Problems with Duke University, Feb. 25-27, Good Samaritan Hospital, W. Palm Bch. For information: Barbara Breznen, P.O. Box 3166, West Palm Beach 33402-3166, (305) 655-5511.

Estrogen Replacement Therapy — Osteoporosis, Feb. 26, Lykes Memorial Hospital, Brooksville. For information: MPR Nathan, M.D., 14540 Cortez Blvd., Brooksville 33512, (904) 596-1822.

Neurological Update, Feb. 26-Mar. 3, Sheraton, Bal Harbour. For info.: Div. of CME, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6716.

Hepatobiliary Disease in Clinical Practice, Feb. 27-Mar. 1, SheratonBal Harbour. For info.: Division of CME, D23-3, 9701 Collins Ave., Bal Harbour 33154, (305) 547-6717.

17th Teaching Conference in Clinical Cardiology, Feb. 27-Mar. 2, Bal Harbour. For info.: Division of Research in Medical Education, Ginny McCans, P.O. Box 016960, Miami 33101, (305) 547-6491.

10th Annual Midwinter Seminar in OB/GYN, Feb. 28-Mar. 2, Don CeSar Beach Resort, St. Petersburg Bch. For info.: Univ. of S. Fla. Medical Ctr., Dept. of Ob/Gyn, Box 18, Tampa 33612, (813) 974-2088.

MARCH

The Cancer Conference, Mar. 1-2, Hilton Hotel, Daytona Beach. For information: H. Kerman, M.D., 570 Memorial Circle, Ormond Beach, (904) 672-1852.

Perplexing Questions for Pulmonary Medicine, March 2, Rusty Pelican, Tampa. For info.: David Solomon, M.D., 13000 N. 30th Street, Tampa 33612, (813) 972-2000, Ext. 152.

Internal Medicine 1985, Mar. 3-8, Sheraton Bal Harbour. For information: Jose Bocles, M.D., Dept. of Medicine R-760, P.O. Box 016760, Miami 33101, (305) 547-6063.

Monitoring Geriatric Medicine, Mar. 4-6, The Good Samaritan Hospital, W. Palm Beach. For info.: Daniel N. Tucker, M.D., P.O. Box 3166, W.Palm Bch. 33402-3166, (305) 655-5511 Ext. 4236.

Mediclinics Postgraduate Medical Refresher Course, Mar. 4-15, Holy Cross Hospital, Ft. Lauderdale. For information: Donald Lannin, M.D., 2917 S. Ocean Blvd., Suite 905, Highland Beach 33431, (305) 272-8973.

Intensive Care for Neurological Trauma and Disease 1985, March 6-10, Sheraton Bal Harbour. For info.: Division of CME D23-3, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6716.

Practical Gynecologic Pathology for the Clinician, Mar. 7-9, Sonesta Bch. Hotel, Key Biscayne. For information: Patience A. Schenck, 600 Maryland Avenue SW, Washington, DC 20024, (202) 638-5577.

Magnetic Resonance Imaging in Medical Practice, Mar. 10-14, Sheraton Bal Harbour. For info.: Manuel Viamonte Jr., M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2680.

Problems in Rheumatology, Mar. 13-16, Don Cesar Hotel, St. Petersburg Bch. For info.: Bernard Germain, M.D., University of South Florida, Box 19, Tampa 33612, (813) 874-2681.

3rd Annual Clinical Management of the Elderly Patient for the Practicing Physician, Mar. 14-16, Americana Dutch Inn, Orlando. For information: Gregor Pawlson, M.D., 7201 Rossville Blvd., Baltimore, MD 21237, (202) 676-4269.

Sarasota national Conference on Pediatric Lung Disease, Mar. 15-17, Sarasota Hyatt House. For information: Gerd Cropp, M.D., 219 Bryant Street, Buffalo, NY 14222, (716) 878-7630.

Surgical Update - 1985 - With Duke University, Mar. 18-20, Good Samaritan Hosptial, W. Palm Bch. For information: Barbara Breznen, P.O. Box 3166, West Palm Bch. 33402, (305) 655-5511.

Update in Clinical Nutrition, March 21, University of South Florida, Tampa. For info.: Jay Mamel, M.D., 12901 N. 30th Street, Tampa 33612, (813) 974-2034.

16th Annual Topics in Internal Medicine, Mar. 21-23, University Centre Hotel, Gainesville. For info.: A. Jay Block, M.D., JHMHC J-233, Gainesville 32610, (904) 392-2666.

Vascular and Pulmonary Disease: Diagnosis and Management, March 22-24, Bahia Mar Hotel, Ft. Lauderdale. For info.: Stephen Mattingly, 5808 S. Rapp Street, Littleton, CO 80120, (303) 798-9682.

Meeting of the International College of Surgeons, Mar. 25-28, Buena Vista Palace, Lake Buena Vista. For info.: International College of Surgeons, 1516 North Lake Shore Drive, Chicago, IL 60610, (312) 642-3555.

4th Annual Symposium on Clinical Management of Diabetes and Endocrine Disorders, March 27-30, Don CeSar Resort Hotel, St. Petersburg. For information: Robert Farese, M.D., JA Haley Veterans Hospital, Bruce B. Downs Blvd., Tampa 33612, (813) 972-2000 Ext. 568.

Interesting Topics in Orthopedics, Mar. 28-30, Royce Hotel, West Palm Beach. For information: Michael Zeide, M.D., 7820 Edgewater Drive, West Palm Beach 33406, (305) 433-0797.

The Diagnosis and Management of the Acute MII, Mar. 29-31, Don CeSar Hotel, St. Petersburg. For info.: Beverly Jacobsen, 64 Inverness Drive East, Englewood, CO 80112, (800) 525-8651.

Current Concepts in Prosthetic Replacement of the Hip and Knee, Mar. 31 - Apr. 3, Sheraton Bal Harbour. For info.: Charles Weiss, M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2121.

Practical Aspects of Newer Cardiovascular and Renal Therapies, Mar. 31-Apr. 3, Hyatt Regency, Orlando. For information: Univ. of Miami, Div. of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

American College of Surgeons Spring Meeting, Mar. 31-Apr. 4, Miami. For info.: American College of Surgeons, 55 East Erie Street, Chicago, IL (312) 664-4050.

APRIL

Spring 1985 Family Practice Review, April 1-5, Sheraton World Center, Orlando. For info.: William Stewart, M.D., JHMHC J-233, Gainesville 32610, (904) 392-3143.

Interventional Radiology, 3rd Annual Seminar, Apr. 2-6, Walt Disney World Village Hotel Plaza, Lake Buena Vista. For info.: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

Trends and Techniques, Apr. 10-12, Hilton Hotel, Lake Buena Vista. For information: Eileen Coulombe, JHMHC J-294, Gainesville 32610, (904) 392-2893.

Issues and Advances in Pediatrics — 1985, Apr. 10-12, Sheraton Sand Key Resort, Clearwater Bch. For information: Lewis Barness, M.D., 12901 N. 30th St., Tampa 33612, (813) 974-4214.

Cardiology Workshop, Apr. 12, Hyatt Regency Hotel, Tampa. For info.: Joseph E. Holland, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (9]4) 398-5667.

Family Practice Weekend — Tampa, Apr. 12-14, Hyatt Regency, Tampa. For info.: Joseph Holland, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (904) 398-5667.

Advanced Cardiac Life Support, Apr. 13-14, Pasco-Hernando Comm. College, New Port Richey. For information: James Marlowe, M.D., P.O. Box 1058, New Port Richey 34291-1058, (813) 842-9574.

Sudden Death - Clinical and Pathological Correlation, Apr. 18-20, Bonaventure Intercontinental Hotel and Spa, Ft. Lauderdale. For information: Esther Cohen, 4300 Alton Rd., Miami Beach 33140, (305) 674-2121.

15th Annual Radiation Therapy Clinical Research Seminar, Apr. 18-20, Gainesville For info.: Hal Jacobson, M.D., JHMHC J-385, Gainesville 32610, (904) 392-3161.

The Current Status of Tissue & Mechanical Heart Valve Replacement, Apr. 27, St. Joseph's Hospital, Tampa. For info.: Dennis Pupello, M.D., 3001 W. Buffalo Ave., Tampa 33677, (813) 870-4130.

MAY

Current Concepts in Pain Management, May 10-29, Mississippi Steamboat Cruise. For information: Dr. Berman, 3301 Johnson St., Hollywood 33021, (305) 989-6650.

Master Approach to Cardiovascular Problems, May 25-27, Contemporary Hotel, Orlando. For information: Yolanda Barcena, Dept. of Medicine, Univ. of Miami, Miami 33101, (305) 549-7124.

JUNE

American & European Views on Critical Care, June 8-15, Cannes, France. For info.: Sonja Craythorne, Dept. of Anesthesiology, Univ. of Miami, Miami 33101, (305) 547-6411.

Coronary Artery Disease and Sudden Death: Primary and Secondary Prevention, June 14-16, Hyatt Grand Cypress, Orlando. For information: Margaret Kleiger, 64 Inverness Dr. E., Englewood, CO 80112, (303) 790-8445.

10th Annual Florida Suncoast Pediatric Conference, June 15-19, Sheraton Sand Key Hotel, Clearwater Beach. For information: Gilbert Pitisci, M.D., 2902 Beach Dr., Tampa 33609, (813) 870-3720

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Topics and Speakers:

Rationale for Chemotherapy
Victor A. Levin, M.D. (University of California)

Cerebral Edema
Leon D. Prockop, M.D. (USF)

CT and NMR Correlates
F. Reed Murtagh, M.D. (USF)

Metastatic Disease and Non-Metastatic Complications
Leon D. Prockop, M.D. (USF)

Recurrent and Malignant Meningioma
David Cahill, M.D. (USF)

Interstitial Radiation
Philip H. Gutin, M.D. (University of California)

Systemic Chemotherapy
Surasak Phuphanich, M.D. (USF)

Intracarotid Chemotherapy
Shashidhar Kori, M.D. (USF)

Intrathecal Chemotherapy
Victor A. Levin, M.D. (University of California)

Complications of Radiation and Chemotherapy
Surasak Phuphanich, M.D. (USF)

Pain Management
Shashidhar Kori, M.D. (USF)

Panel Discussion
All participants and attendees

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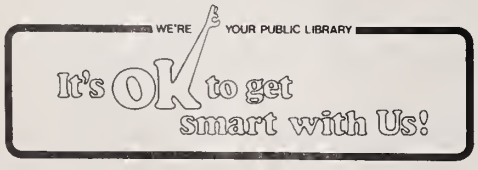
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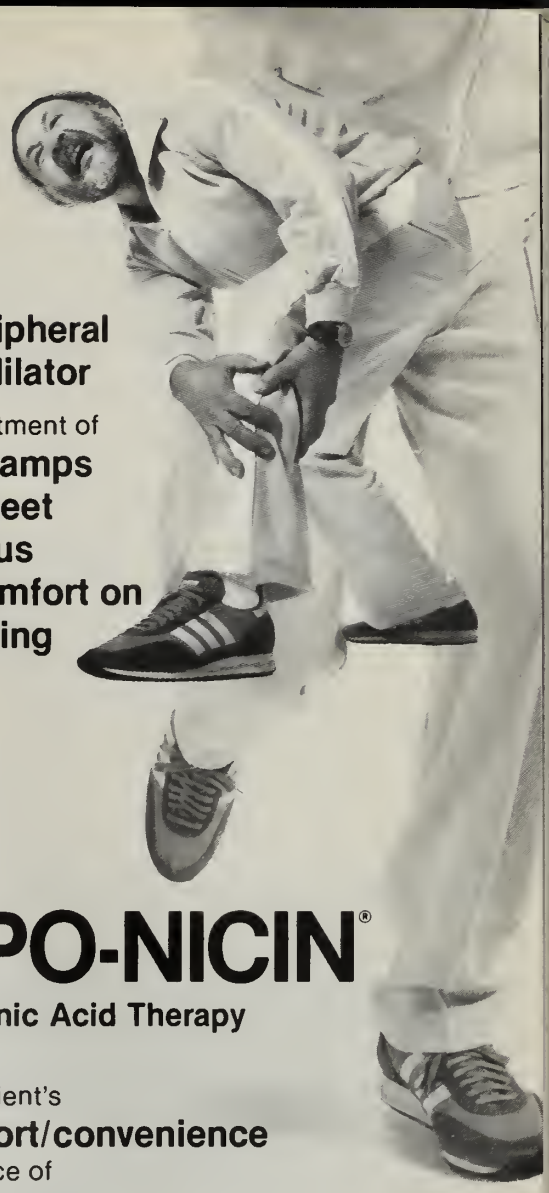
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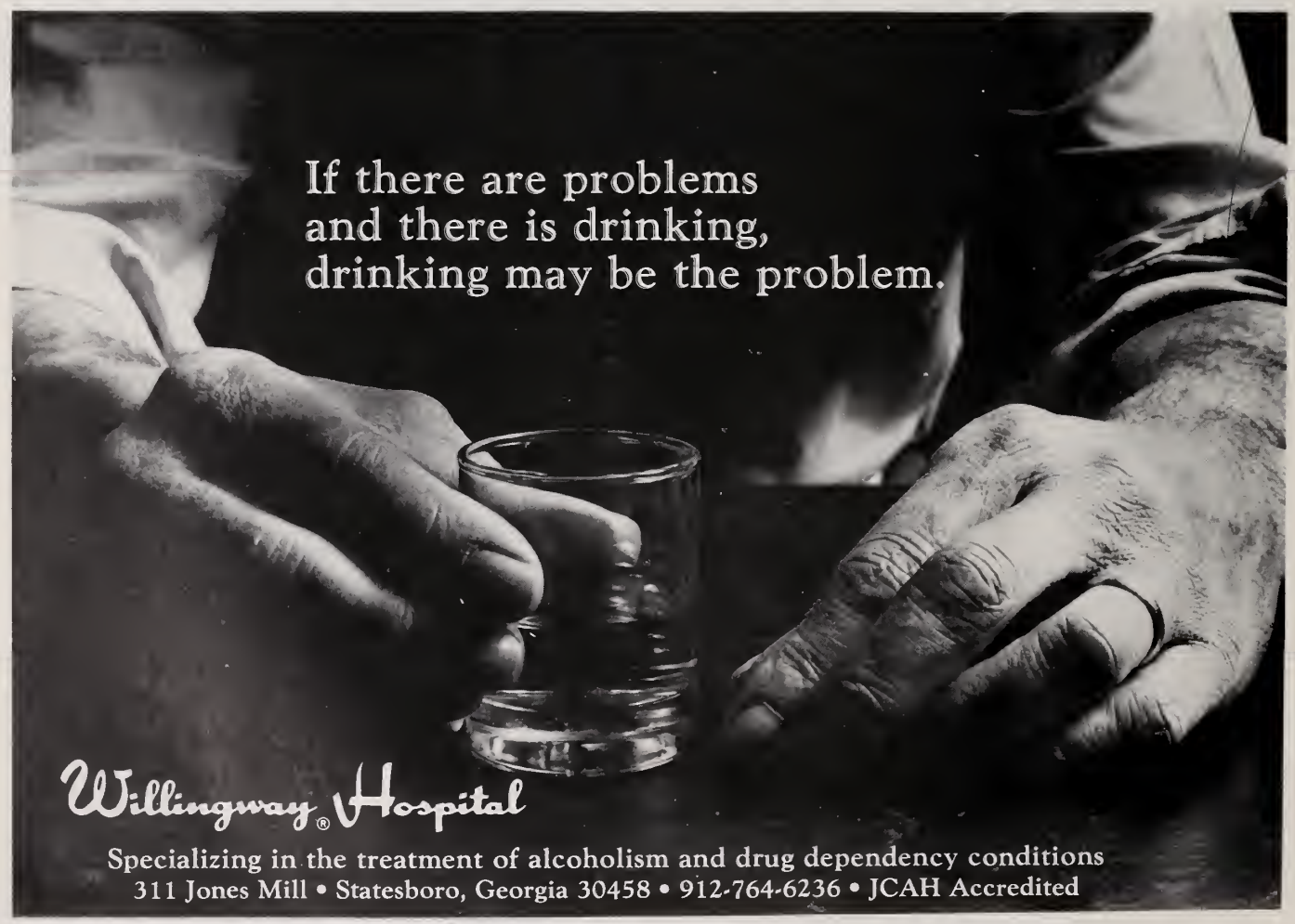
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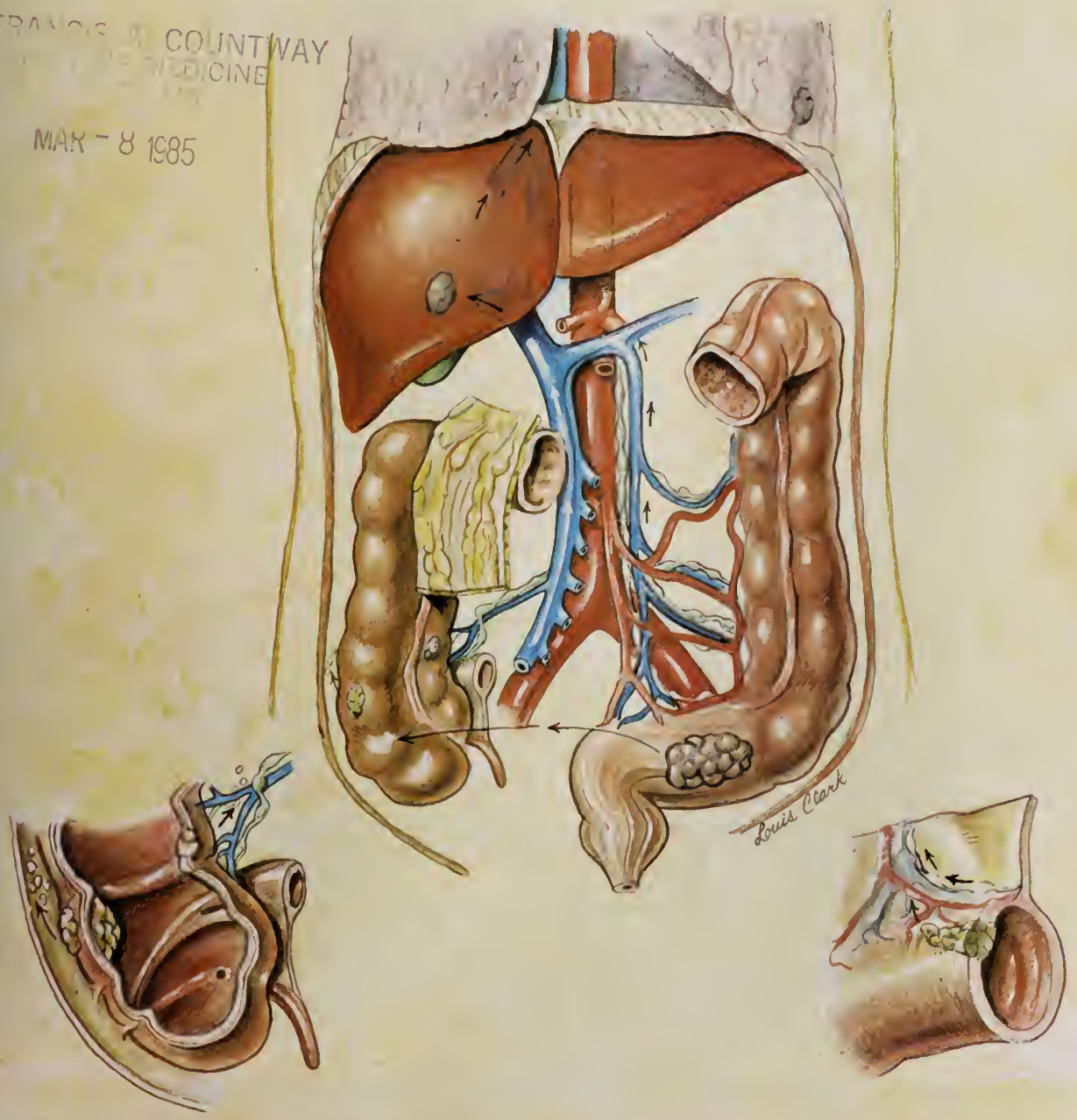
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Summary of the FMA Board of Governors Meeting January 12, 1985

The following is a summary of the major actions taken by the Board of Governors at its meeting January 12, 1985.

THE BOARD:

Florida Physicians' Insurance Reciprocal

Received the final report from the accounting firm of Ernst & Whinney which provides an in-depth review of the finances and operation of the Florida Physicians' Insurance Reciprocal. The independent audit was requested at the October 1984 meeting of the Board of Governors and was mailed to each member of the Florida Medical Association on January 4, 1985.

In a hearing held January 3, 1985 in Tallahassee, Circuit Judge Charles E. Miner, Jr., terminated the rehabilitation of the Florida Physicians' Insurance Reciprocal and returned the company to its new management, the Physicians Insurance Company of Ohio (PICO). In terminating the rehabilitation, the Court found that the Receiver's Plan of Rehabilitation had been complied with and the Reciprocal could be returned to its new management without further jeopardy to the insurer and its creditors, claimants, subscribers or to the public. The Board of Governors believes that the termination of the rehabilitation will remove the current cloud of uncertainty about the Reciprocal's future and will enhance the ability of the Reciprocal to gain subscribers and will assure the ability of the Reciprocal to regain its former position in the market as a financially sound and competently managed company. The FPIR will be converted to a stock company at the earliest possible date in 1985.

Legislative Program Review

Received a comprehensive report on the review of the FMA legislative program and political education activities. The review as conducted by a team of consultants consisting of Mr. Bill Roberts of the AMA Division of Medical Society Relations; Mr. Robert Klinglesmith, Associate Executive Director of the Kentucky Medical Association; and Mr. Greg Hooser, Legal Counsel of the Texas Medical Association. The review included the FMA's legislative, PAC, and field services activities; its relationships with the Auxiliary, with county medical societies, and with other groups in the health field that have legislative interests. The final report indicates that generally, the FMA's legislative efforts have historically been very effective and with the exception of its tort reform effort, compares very favorably with that of most other state medical associations.

The report and recommendations of the consultants have received very careful study and steps are already underway to implement the recommendations, which include:

- Careful evaluation of all staff responsibilities for the FMA legislative and political education activities with appropriate action as necessary to clarify and delineate the role, lines of authority and responsibilities and functions of the FMA Headquarters Office, Capital Office and field offices to ensure the best possible coordination and operational efficiency in carrying out these activities.

- Expanding the responsibilities of the Council on Legislation in carrying out the policies of the House of Delegates using general guidelines established by the Board of Governors.

- Strengthen working relationships with county medical societies with these efforts directed both at the executives of the county

medical societies and the physician members.

- Strengthen and expand the cooperative efforts with the Auxiliary in our legislative and political education activities.
- Development of a better working relationship with specialty societies and their lobbyists if these societies have such lobbyists.
- Develop a better working relationship with other labor groups such as business organizations, labor unions, civic and senior citizen organizations.
- Improve liaison with the executive and regulatory branches of the Florida government.
- Incorporate in the FMA legislative program issues other than those that are perceived by the public and the legislature to be solely for the benefit of physicians.
- Expand FLAMPAC activities to include more assistance to candidates such as benchmark surveys, demographic studies, independent expenditures and more physician and spouse participation in the candidate's campaign.
- Maximize efforts to keep physicians informed of the Association's legislative programs and activities.

1984 FMA Assessment — Delinquent Members

Directed that aggressive efforts be made to collect the 1984 assessment for professional liability, and further, that no member who is currently delinquent in paying the 1984 assessment be dropped from membership in the FMA until all efforts are exhausted to collect the assessment; and further, at the Joint Meeting of the Board of Governors with county medical society officers and executive directors to be held in conjunction with the FMA Leadership Conference, that this subject be discussed in detail and that the county medical society presidents be requested to appoint an appropriate committee within the county medical society to assist the president of the society in personally contacting in a positive manner each delinquent member in their society, and further, if the county medical society leadership does not feel this contact can be carried out, that the FMA Board of Governors, and Council and Committee Chairmen assume personal responsibility for aggressive efforts to collect the delinquent assessments.

The Board noted that if these efforts are not successful the appropriate disciplinary action would have to be taken regarding those members who have not paid the assessment, including the possible loss of membership.

COMMITTEE ON PROGRAMS AND PRIORITIES

Reviewed a preliminary report and recommendations from the Committee on Programs and Priorities and approved the following recommendations:

> [This Committee was established by the Board of Governors and charged with reviewing the current programs and priorities of the Association to determine if they appropriately reflect the best interest of the physicians in Florida and their patients as well as the many complex issues facing medicine in Florida and the entire country.]

Medical Education

The Florida Medical Association become more involved with medical education at all levels from undergraduate and residency training programs, through continuing medical education for practicing physicians.

CME

To refer to the Committee on Medical Education of the Council on Scientific Activities for review, the recommendation that the FMA eliminate continuing medical education as a requirement for membership and establish a voluntary CME program with widespread public recognition to those who receive certification for CME.

Public Relations

The FMA expand its public relations program within the fiscal resources of the Association.

Allied Health Organizations

The FMA reaffirm the goals previously adopted at the October Board Meeting for the Committee on Health Manpower as follows:

- Identify those allied health groups that anticipate expanded activities through legislation or regulatory means.
- If possible, identify the goals of each allied health group.
- Develop an adequate data base for use by FMA, the staff, and councils and committees for communicating with allied health groups.
- Develop a data base on physician manpower in Florida with identification of areas of shortages and

what steps are being taken to correct these shortages.

- Develop a roster of expert witnesses who will be available upon short notice to represent the FMA at legislative hearings.

- Cooperate with other agencies and groups to remove problems with foreign trained health care professionals.

Voluntary Health Agencies — That FMA establish a mechanism to enhance liaison with voluntary health agencies.

Mailed Communications — Referred back for further study and review as to the cost benefit ratio, the recommendation that the Florida Medical Association distribute the *Briefs* and *Graypaper* as a single communication, and that this communication be distributed monthly as opposed to quarterly.

GTE/MINET — Directed that FMA actively promote the installation and utilization of the GTE/MINET System (Computerized Medical Data Bases and Electronic Mail) with the FMA field offices, county medical societies and specialty societies with offices.

Financial Report — That each year at the First Session of the Annual Meeting of the House of Delegates, the Treasurer provide a written report on the Association's finances to each member of the House of Delegates, present a verbal explanation of the report, and respond to questions in an appropriate forum.

Medico-Legal Hot Line — Referred to the Executive Director for a report back to the Executive Committee on the fiscal impact of the recommendation that the FMA establish a medico-legal hot line to assist physicians confronted with potential medical-legal difficulties.

FMA Annual Meeting — Approved the recommendation that the FMA move the Annual Meeting to September by 1987 and beginning with the 1986 Annual Meeting, if possible, and that a business meeting of the House of Delegates be held in January of 1986 or 1987 in order to facilitate the transition to the September Annual Meeting. The Board referred back to the Committee for further study in consultation with the Council on Scientific Activities' recommendations regarding the format and length of the Annual Meeting.

Increase Membership — That FMA give high priority to efforts for increasing membership at all levels.

Auxiliary — That FMA continue its cooperative and mutually advantageous relationship with the Auxiliary, whose ability to assist in the area of legislation, political education, cultural, philanthropic and any other meaningful activity is essential.

Specialty Society Vote in House of Delegates — Expressed strong support and approval for the recommendation that each specialty group recognized by the FMA have a voting delegate and alternate delegate in the FMA House of Delegates provided no delegate would have more than one vote.

Specialty Society Legislative Activities — That FMA continue its efforts to coordinate the legislative activities of specialty societies in concert with the FMA legislative program, subject to the understanding that this recommendation is being implemented through the Council on Legislation.

Specialty Society Administrative Support — That FMA offer to provide full or part-time administrative support, subject to appropriate financial arrangements, to all specialty societies requesting such, and further, that the FMA Chief Executive Officer meet regularly with specialty group staffs.

Restructuring of the Board of Governors — Approved as amended the recommendation regarding the composition of the FMA Board of Governors:

- That future vacancies on the Board of Governors from each medical district be elected by the House of Delegates for a term of four years beginning in 1986; and further, that the "at large" member of the Board of Governors be replaced by a resident physician who shall be elected by the House of Delegates for a term of two years beginning in 1986.

- That the office of Secretary and Treasurer not be combined.

- That the entire composition of the Board be considered at the March 1985 Meeting of the Board of Governors.

The Board commended the Committee on Programs and Priorities for the outstanding manner in which they carried out their responsibilities and duties in respect to the Committee's initial report and recommendation.

AMA — GTE/MINET — Approved the recommendation that the FMA offer to provide component county medical societies and specialty groups with necessary equipment to have access to the AMA MINET Communications Network with the actual cost of the equipment to be reimbursed to the FMA either in the total amount or through monthly

repayment, and further, that this equipment be made available to members of the Board of Governors.

Resolution — Michael H. Lopez, Jr.

Expressed deep regret over the sudden and unexpected death of Mr. Michael Lopez, Executive Vice President of the Palm Beach County Medical Society and adopted the following resolution:

> Whereas, Mike Lopez met an untimely death on December 22, 1984; and
>
> Whereas, Mike Lopez was a steadfast friend of organized medicine and to all physicians and physicians' families; and
>
> Whereas, Mike Lopez worked untiringly for the Palm Beach County Medical Society making it one of the most respected and effective component medical societies; and
>
> Whereas, Mike Lopez was a personal friend to many members of organized medicine; therefore be it
>
> RESOLVED, That the Florida Medical Association pay an official tribute to Mike for his many contributions to organized medicine, and send a report of this action to his family in an expression of our deepest condolence.

COUNCILS AND COMMITTEES

COUNCIL ON LEGISLATION

Professional Liability

Approved support for solutions for resolving the professional liability crisis that will achieve stability in respect to the current cost of professional liability insurance and will provide to patients who are truly injured in the medical system an opportunity to be adequately and efficiently compensated for their injuries, and further, that the FMA support the following concepts as solutions that meet the criteria set out above:

Tort Modification Package

- Caps on awards
- Structured settlements
- Eliminate joint and several liability, or

Alternative resolution of malpractice disputes through any of the following, but not limited to:

- Modified "No-Fault" or "Worker Compensation" approach
- Arbitration
- Screening panels
- "Trip Insurance"
- Other effective alternatives that might be identified

General solutions that would be considered upon the approval of the concepts contained in either Category 1 or 2.

- Strengthening risk management programs
- Strengthening the ability of the Board of Medical Examiners to deal with incompetent physicians
- Consider the feasibility of mandatory insurance for physicians {This concept is linked specifically to the elimination of joint and several liability.}

Standards of Recovery for Medical Negligence

Endorsed changing the burden of proof for medical negligence from "the greater weight of evidence", to "clear and convincing evidence", and that the FMA legal counsel and appropriate defense attorneys be requested to offer an opinion as to the extent of benefit this change would present.

Contingency Fee System

Requested that the Florida Legislature and the Florida Supreme Court continue to critically review the contingency fee system and the potential inequities therein in order to maximize patient compensation in instances of medical malpractice.

Physician Discipline

Recognized the need for development of legislation to provide additional information that may be necessary for the State Board of Medical Examiners to carry out disciplinary provisions of the Medical Practice Act in the most efficient manner possible.

Workers' Compensation Fee Schedule

Directed that FMA continue to aggressively pursue via the administrative process, the resolution of inequities in the Workers' Compensation fee schedule, and that the adoption of any specific legislative objectives of the FMA be deferred for the time being.

Other Legislative Issues

Adopted general positions on other legislative issues as follows:

Support:

- Foreign Medical Graduates: Recommended changes that are to be developed by the appropriate representative of the medical schools in Florida and the FMA Council on Scientific Activities in concert with existing state boards and agencies, to assure that only qualified and competent physicians are granted licensure to practice medicine in Florida.

- Trauma Centers: The concept of regional designated trauma centers in Florida to provide for optimal care of the critically injured patient, as provided in the Department of Health and Rehabilitative Services draft legislation.

- Clean Indoor Act: Establishment of the Clean Indoor Act that prohibits smoking in public places, except in designated smoking areas.

- Community Hospital Education Act: Continued funding for the Community Hospital Education Act to assist in residency training for primary care physicians.

Oppose:

- Pharmacists Prescribing: Authorization for certain "Self-Care Consultants" to prescribe drugs contained in a formula without examination and diagnosis by a physician.

- Chiropractic School: $150,000 appropriation to establish a school of chiropractic in Florida.

- Mandated Insurance for Chiropractic Services: Mandate for all insurance policies to include payment for chiropractic services.

- Use of Drugs by Optometrists: Authorization for optometrists to use or prescribe drugs in diagnosis and treatment of medical problems of the eye.

- Hospital Staff Privileges for Non-Physicians: Mandated hospital staff privileges for non-physicians.

- Amendments to Medical Practice Act: Any further exemptions being created in the Medical Practice Act would bypass present licensure requirements.

COUNCIL ON MEDICAL ECONOMICS

Physician Contracting Guide

Approved the development of a physician's guide on contracting and negotiating with alternative health care delivery systems in hospital programs.

Exhange of Information

Approved the recommendation that the FMA interact with the Office of Technical Assistance, now in the Department of Insurance to be transferred to the Governor's office by December 1985 for the purpose of exchanging information regarding alternative health delivery systems.

Indigent Care

Approved the development of recommendations to submit to the proper governmental authorities to address the issue of adequate health care for the indigent, and further, that the Council be requested to proceed with the recommendation in concert with the Council on Legislation.

Primary Care

Urged the Department of Health and Rehabilitative Services that an ongoing status report of the DHRS Primary Care Program be provided to the FMA and the following four specialty societies regarding the appropriate designation to areas with significant needs for primary care:

Florida Academy of Family Physicians
The Florida Pediatric Society
The Florida Obstetric and Gynecologic Society
The Florida Society of Internal Medicine

Medicaid

Directed that the FMA examine all alternative prepaid Medicaid plans and determine the extent of funding needed to establish such programs for implementation through county medical societies.

COUNCIL ON MEDICAL SERVICES

Environmental Hazards

Supported legislation to expand Chapter 381, Florida Statutes, to include reporting of diseases (Morbidity and Mortality) related to environmental hazards.

Occupational Disease

Approved the FMA support for institution of an occupational health program at the state level within the Health Program Office to assess the magnitude of occupational disease in Florida.

Hepatitis B

Supported the development of a policy on management of Hepatitis B in state institutions and among clients and employees of the Florida Department of Health and Rehabilitative Services to be transmitted to the Health Program Office of HRS.

Public Health — Public Relations Program

Approved an FMA public health education program directed at the general public and the medical profession; and further, that this program be accomplished through the production and distribution of radio and television public service announcements addressing such themes as driving and drinking, use of drugs, automobile safety belts and smoking.

Septic Tanks in Industrial Parks

Urged the Health Program Office to reconsider its interpretation of Section 381.272(9), Florida Statutes,

particularly its assumption that septic tanks in industrial parks will not be used for disposal of toxic or hazardous chemicals in that all septic tanks in industrial parks have the potential for disposal of toxic or hazardous chemicals.

Substance Abuse and Chemical Education K through 12

Adopted the following position with regard to substance and chemical abuse education in Florida schools up to grade 12:

- Urge the Legislature to place more emphasis on the teaching of health education, including substance abuse, in the elementary, middle schools, and high schools.
- Recommend to the Legislature that Section 230.2319, Florida Statutes, known as Florida Progress in Middle Childhood Education Program (PRIME) be amended to mandate the teaching of health education, including substance abuse, stress management and emotional health in grades 4 through 5 and 6 through 8. As it currently exists, this law provides only limited health education in middle grades.
- Recommend to the Legislature that teacher certification requirements include an in-depth course in health education and substance abuse. The main focus of the curriculum should be on prevention, but it should also include identification of the signs and symptoms of substance abuse and the procedures for intervention with students and their families.
- Commended the Legislature for passage of the required one semester life management skills course, to be taken in the 9th or 10th grade. The Legislature should be alerted to the fact that this is the last time students will be involved in health education and substance abuse courses. It would be of value to students if an additional course at the 11th and 12th grade level would be required since the quality of life is so dependent on an individuals health.
- Recommend to the Legislature continued categorical funding for comprehensive health education.

Hand Washing Facilities in the Schools

Recommended to the Florida Department of Education that proper hand washing by schools students is one act of personal hygiene that can reduce the spread of many communicable diseases in the school setting, and further, urged the Department to adopt requirements for new school construction that will assure the installation of adequate numbers of conveniently located sinks for hand washing.

Isolete Cell Antibody — Diabetes Study

Reaffirmed FMA endorsement of research being conducted at the University of Florida by Knoll K. Maclaren, M.D., and others, entitled "Isolete Cell and Autoantibodies and the Naturual History of IDD."

COUNCIL ON SPECIALTY MEDICINE

Specialty Group Recognition Approvals

Approved continuing recognition for the following specialty groups who have met the criteria established by the House of Delegates for recognition by the Association:

The Florida Society of General Surgeons
The Florida Society of Rheumatology

COUNCIL ON SCIENTIFIC ACTIVITIES

Scientific Program 111th Annual Meeting

Accepted as information a report on the Scientific Program of the 111th Annual Meeting.

As of the date of the report, 22 specialty societies had indicated their intention to participate in a scientific section. A symposium entitled "Quality Medicine in a Rapidly Changing Environment" is planned for Thursday, May 2, 1985 from 4:00 p.m. to 5:00 p.m. Final plans for a speaker will be reported at the March Board of Governors Meeting. The Council plans to significantly enhance the Scientific Program through its sponsorship of an additional section on Bioethics and an outstanding workshop on "The Basics of Searching Medline" which will be repeated several times during the Annual Meeting for the convenience of program participants.

FMA Journal Editor

Expressed gratitude to Daniel B. Nunn, M.D., for his outstanding contributions as Editor of *The Journal of the Florida Medical Association, Inc.*, for the past five years.

COUNCIL ON HOSPITAL MEDICAL STAFFS

Received an update on the formation of the Council on Hospital Medical Staffs and the establishment of short and long-range goals of the Council:

Long-Term Ongoing Goals

- Study the changing medical care environment and its potential

effect on hospital medical staffs and organized medicine.

- Development of services necessary to strengthen hospital/health facility medical staffs.

- To increase awareness of issues that are affecting physicians as members of medical staffs.

- To provide an avenue for hospital medical staffs to have access to the policymaking body of the FMA.

Short-Term Goals

- Develop and study methods for implementing risk management from the point of view of the physician as he functions as a member of his hospital medical staff.

- Encourage the development of local county hospital medical staff committees by providing the support and assistance as needed.

- Study the effect of Auxiliary Health Professionals gaining hospital privileges in the practice of medicine as well as their impact on the cost of medical care.

- Encourage county hospital medical staff committees' participation in the FMA Council on HMS and the AMA HMSS.

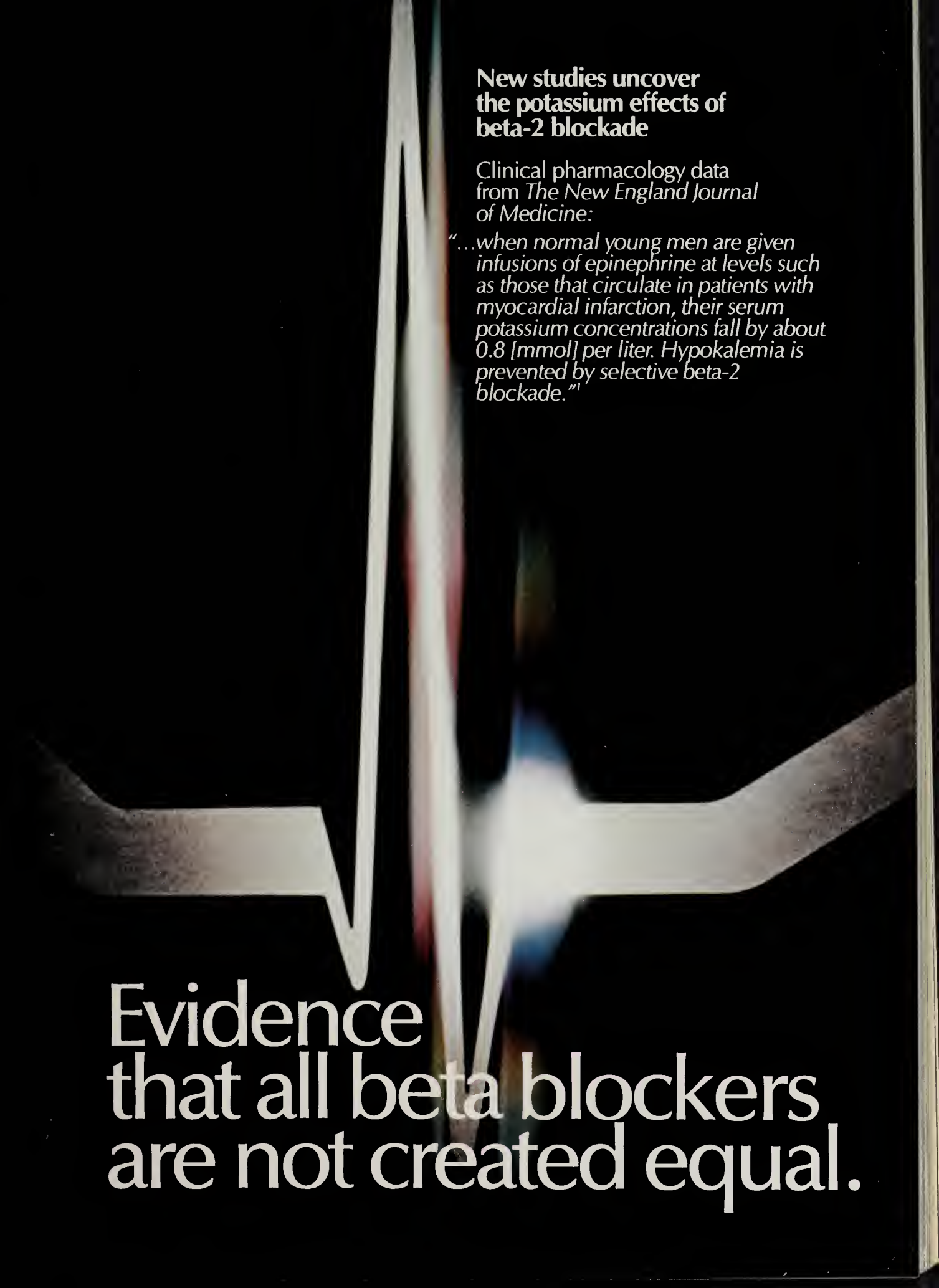
- Develop a program that would improve the hospital medical staff voice in hospital planning.

- Inform the membership of activities of the Council on a quarterly basis in conjunction with the Board of Governors Meeting through a Council on Hospital Medical Staffs Newsletter.

COMMITTEE ON MEMBERSHIP DEVELOPMENT

Medical Student and Resident Members

Approved the recommendation that the FMA establish a medical student section and a resident physician section.



New studies uncover the potassium effects of beta-2 blockade

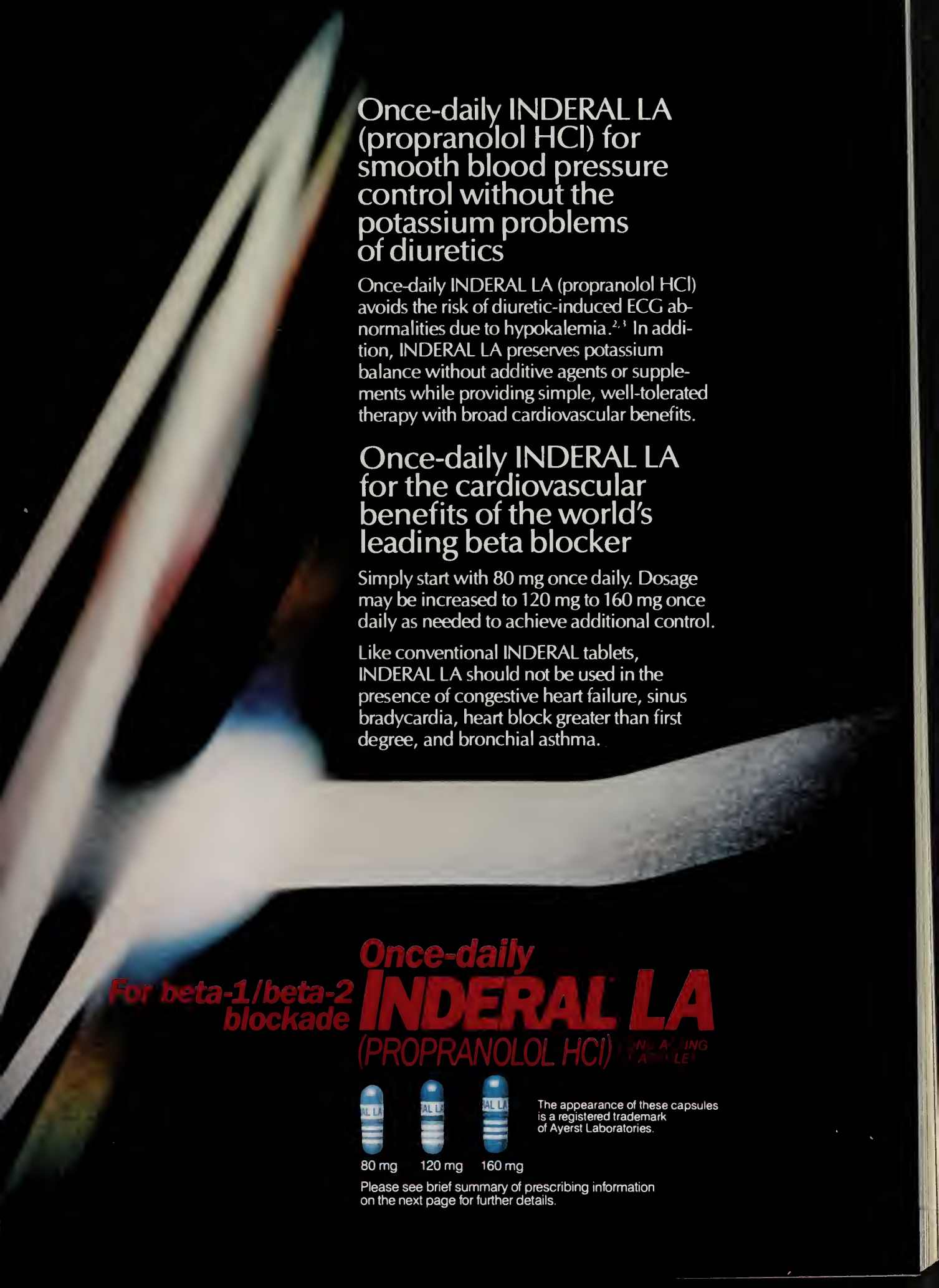
Clinical pharmacology data from *The New England Journal of Medicine:*

"...when normal young men are given infusions of epinephrine at levels such as those that circulate in patients with myocardial infarction, their serum potassium concentrations fall by about 0.8 [mmol] per liter. Hypokalemia is prevented by selective beta-2 blockade."[1]

Evidence that all beta blockers are not created equal.

Right from the start in hypertension...





Once-daily INDERAL LA (propranolol HCl) for smooth blood pressure control without the potassium problems of diuretics

Once-daily INDERAL LA (propranolol HCl) avoids the risk of diuretic-induced ECG abnormalities due to hypokalemia.[2,3] In addition, INDERAL LA preserves potassium balance without additive agents or supplements while providing simple, well-tolerated therapy with broad cardiovascular benefits.

Once-daily INDERAL LA for the cardiovascular benefits of the world's leading beta blocker

Simply start with 80 mg once daily. Dosage may be increased to 120 mg to 160 mg once daily as needed to achieve additional control.

Like conventional INDERAL tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.

For beta-1/beta-2 blockade

Once-daily INDERAL LA

(PROPRANOLOL HCl)

80 mg 120 mg 160 mg

The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Please see brief summary of prescribing information on the next page for further details.

Once-daily For beta-1/beta-2 blockade INDERAL® LA (PROPRANOLOL HCl) LONG ACTING CAPSULES



The appearance of these capsules is a registered trademark of Ayerst Laboratories.

BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*
INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**
DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.
CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.
INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension, it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.
CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.
WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely; or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of receptor agonists and its effects can be reversed by administration of such agents, dobutamine or isoproterenol. However, such patients may be subject to protracted s hypotension. Difficulty in starting and maintaining the heartbeat has also been reported beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the pearance of certain premonitory signs and symptoms (pulse rate and pressure change acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroi Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symp of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have reported in which, after propranolol, the tachycardia was replaced by a severe bradyc requiring a demand pacemaker. In one case this resulted after an initial dose of propranolol.
PRECAUTIONS. *General:* Propranolol should be used with caution in patients with imp hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatme hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Pa should be told that INDERAL may interfere with the glaucoma screening test. Withdrawa lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart dis elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as pine should be closely observed if INDERAL is administered. The added catechola blocking action may produce an excessive reduction of resting sympathetic nervous a which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or ortho hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals been conducted to evaluate toxic effects and carcinogenic potential. In 18-month stud both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of signi drug-induced toxicity. There were no drug-related tumorigenic effects at any of the do levels. Reproductive studies in animals did not show any impairment of fertility tha attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryoto animal studies at doses about 10 times greater than the maximum recommended human There are no adequate and well-controlled studies in pregnant women. INDERAL s be used during pregnancy only if the potential benefit justifies the potential risk to the

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.
ADVERSE REACTIONS. Most adverse effects have been mild and transient and rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, tension, paresthesia of hands, thrombocytopenic purpura, arterial insufficiency, usually Raynaud type.

Central Nervous System: lightheadedness, mental depression manifested by insc lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, disturbances, hallucinations, an acute reversible syndrome characterized by disorientat time and place, short-term memory loss, emotional lability, slightly clouded sensorium decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, dia constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with a and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocyto purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male tence, and Peyronie's disease have been reported rarely. Oculomucocutaneous rea involving the skin, serous membranes and conjunctivae reported for a beta blocker (pra have not been associated with propranolol.
DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochlori sustained-release capsule for administration once daily. If patients are switched from IN tablets to INDERAL LA capsules, care should be taken to assure that the desired therá effect is maintained. INDERAL LA should not be considered a simple mg for mg substi INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitratic be necessary especially to maintain effectiveness at the end of the 24-hour dosing ir

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is INDERAL LA once daily, whether used alone or added to a diuretic. The dosage r increased to 120 mg once daily or higher until adequate blood pressure control is acl The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage mg may be required. The time needed for full hypertensive response to a given dos variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDEF once daily, dosage should be gradually increased at three to seven day intervals until o response is obtained. Although individual patients may respond at any dosage le average optimum dosage appears to be 160 mg once daily. In angina pectoris, the va safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDE once daily. The usual effective dose range is 160-240 mg once daily. The dosage increased gradually to achieve optimum migraine prophylaxis. If a satisfactory respons obtained within four to six weeks after reaching the maximum dose, INDERAL LA should be discontinued. It may be advisable to withdraw the drug gradually over a p several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.
PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group limited to permit adequate directions for use.
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FEBRUARY 1985 Vol. 72, No. 2

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This month's cover of *The Journal* is a drawing by Mr. Louis Clark, University of Florida Department of Learning Resources and Communications, Gainesville. This illustration depicts contemporary surgical management of hepatic metastases of colorectal origin.

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New study reveals no interaction betwee



Ativan® (lorazepam) and Darvon® (propoxyphene HCl) Ⓒ Ⓘ Ⓥ

In a study evaluating the influence of propoxyphene coadministration on the pharmacokinetics of the oxidatively metabolized benzodiazepines Xanax® (alprazolam) Ⓒ and Valium® (diazepam) Ⓒ, and a benzodiazepine metabolized by conjugation, Ativan® (lorazepam), the following results were reported:

with Xanax, propoxyphene caused a large and highly significant prolongation of half-life and impairment of total metabolic clearance.[1]

in the case of Valium, propoxyphene produced a small but not statistically significant impairment of clearance.[1]

propoxyphene had no apparent effect on the distribution, half-life or clearance of Ativan.[1]

In this randomized crossover study, eight healthy male and female volunteers received single oral doses of alprazolam (1 mg), six received single IV doses of diazepam (10 mg), and five received single IV doses of lorazepam (2 mg), once in a drug-free control state and again during coadministration of propoxyphene (65 mg q6h). Consistent with previous findings, this study evidences that Ativan does not interact with drugs that undergo oxidative metabolism.[2,5] In contrast to most other benzodiazepines, Ativan does not compete for the cytochrome P-450 enzyme system.

The clinical implications of the pharmacokinetic interaction, or non-interaction, of propoxyphene with benzodiazepines are not established by this study. Even without a pharmacokinetic interaction, propoxyphene and benzodiazepines share central depressant properties and therefore should be coadministered with suitable caution. A concurrent pharmacokinetic interaction indicates a need for even further caution. Coadministration of propoxyphene and alprazolam, for example, would produce not only the expected pharmacodynamic interaction, but also whatever additional central depressant effect would be produced by the elevated steady-state plasma concentrations of alprazolam due to its impaired clearance.

Caution should also be observed when propoxyphene is prescribed for patients who use alcohol to excess.

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Brief Summary of Prescribing Information.

Indications and Usage: Managamant of anxiaty disordars or short-tarm ralief of symptoms of anxiaty or anxiaty associatad with daprassiva symptoms. Anxiaty or tansion associated with strass of avaryday lifa usually does not requira traatmant with an anxiolytic.

Effectivaness in long-tarm use, i.a., mora than 4 months, has not been assessed by systamatic clinical studias. Raassess periodically usefulnass of tha individual patiant.

Contraindications: Known sensitivity to benzodiazapinas or acuta narrow-angla glaucoma.

Warnings: Not recommanded in primary daprassiva disordars or psychoses. As with all CNS-acting drugs, warn patiants not to operata machinary or motor vahicles, and of diminished tolaranca for alcohol and othar CNS daprassants.

Physical and Psychological Dependanca: Withdrawal symptoms lika thosa noted with barbituratas and alcohol have occurred following abrupt discontinuanca of benzodiazapinas (including convulsions, tremor, abdominal and muscla cramps, vomiting and swaating). Addiction-prone individuals, a.g. drug addicts and alcoholics, should be undar caraful survaillanca whan on benzodiazapinas because of their pradisposition to habituation and dapendanca. Withdrawal symptoms hava also been reported following abrupt discontinuanca of benzodiazapinas takan continuously at tharapeutic levels for several months.

Precautions: In daprassion accompanying anxiaty, considar possibility for suicida.

For eldarly or dabilitatad patiants, initial daily dosega should not exceed 2mg to avoid ovarsedation. Tarminate dosaga gradually sinca abrupt withdrawal of any antianxiaty agant may rasult in symptoms lika those being treated: anxiaty, agitation, irritability, tansion, insomnia and occasional convulsions. Observe usual precautions with impaired ranal or hapatic function. Whara gastrointastinal or cardiovascular disordars coexist with anxiaty, nota that lorazapam has not been shown of significant benefit in treating gastrointastinal or cardiovascular componant. Esophagaal dilation occurred in rats traated with lorazepam for mora than 1 year at 6mg/kg/day. No affect dose was 1.25mg/kg/day (about 6 times maximum human tharapeutic dose of 10mg/day). Effact was ravarsibla only whan traatmant was withdrawn within 2 months of first observation. Clinical significanca is unknown; but usa of lorazepam for prolongad periods and in gariatrics requiras caution and fraquant monitoring for symptoms of upper G.I. disease. Safety and affectivanass in childran undar 12 yaars hava not been established.

ESSENTIAL LABORATORY TESTS: Soma patiants hava davaloped laukopenia; soma hava had elevations of LDH. As with other benzodiazepines, periodic blood counts and livar function tasts ara recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazapinas produce CNS daprassant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potantial emarged in rats during an 18-month study. No studies regarding mutaganesis hava been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsels, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosege. Although all these anomalies were not present in the concurrent control group, thay hava been raported to occur randomly in historical controls. At 40mg/kg and higher, thare was evidence of fatal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamata) during first trimaster of pregnancy has been suggested in several studies. Because use of these drugs is rarely a mattar of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of tharapy should be considered. Advise patients if they become pregnant to communicata with their physician about dasirability of discontinuing the drug. In humans, blood levals from umbilical cord blood indicata placantal transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excrated in human milk lika othar benzodiazepines. As a general rula, nursing should not be undertakan whila on a drug sinca many drugs are excreted in milk.

Adversa Raactions, if they occur, ara usually observed at beginning of tharapy and generally disappear on continued medication or on decraasing dose. In a sampla of about 3,500 anxious patients, most frequent advarsa reaction is sedation (15.9%), followed by dizziness (6.9%), waaknass (4.2%) and unsteadiness (3.4%). Lass frequant ara disoriantation, daprassion, nausea, changa in appetita, headacha, sleep disturbanca, agitation, darmatological symptoms, aya function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidanca of sedation and unsteadiness incraased with age. Small decraases in blood prassura hava been noted but ara not clinically significant, probably being ralatad to raliaf of anxiaty.

Transient amnesia or mamory impairmant has been raported in association with the usa of benzodiazepines.

Overdosaga: In managemant of ovardosaga with any drug, bear in mind multipla agants may hava bean takan. Manifastations of overdosaga includa somnolance, confusion and coma. Induca vomiting and/or undartake gastric lavaga followed by ganeral supportiva care, monitoring vital signs and close observation. Hypotansion, though unlikely, usually may be controlled with Levartaranol Bitartrata Injection U.S.P. Usafulness of dialysis has not been datarmined.

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Long range planning for the Florida Medical Association



The FMA Bylaws give the Executive Committee of the Board of Governors the responsibility for long range planning. Because the practice of medicine is changing so fast in the current health care delivery revolution, the Executive Committee needed assistance in long range planning. In May 1984, a Programs and Priorities Committee was established to make a careful review of all programs and priorities of the FMA so as to determine whether they accurately reflect the best interests of the physicians in Florida and their patients.

This Committee was charged with the responsibility of making recommendations to the Executive Committee after carrying out a detailed review of programs of programs and priorities. The Committee held five regional meetings that were attended by its members and representatives of county medical societies in the geographic area. These meetings were held in Jacksonville, Pensacola, Orlando, Tampa and Miami.

Spirited discussion took place at each of the meetings, which indicated some dissatisfaction and frustration about many of the activities of the FMA. The Committee Report contained more than twenty recommendations, which were considered first by the Executive Committee and then by the Board of Governors.

These recommendations are too numerous to be included in their entirety in this President's Page, but I am including the ones that I believe to be the most important. The recommendation of the Committee will be presented, followed by the action that has been taken on the recommendation.

Recommendation: Mandatory Continuing Medical Education Requirement • THAT THE FMA ELIMINATE THE NEED FOR CONTINUING MEDICAL EDUCATION AS A REQUIREMENT FOR MEMBERSHIP AND ESTABLISH A VOLUNTARY CME PROGRAM WITH WIDESPREAD PUBLIC RECOGNITION TO THOSE WHO RECEIVE CERTIFICATION FOR CME.

Action • This recommendation has been approved by the Board and will be submitted to the House of Delegates for appropriate action in May.

Recommendation: Public Relations Program • THAT THE FMA IMPLEMENT A COMPREHENSIVE PUBLIC RELATIONS PROGRAM TO INCLUDE ALL PHASES OF MEDIA WHICH WILL PROMOTE THE POSITIVE IMAGE OF PHYSICIANS; AND FURTHER, THAT THE FMA EARMARK A PORTION OF DUES AND OTHER INCOME FOR PUBLIC RELATIONS EXCLUSIVELY.

Action • This recommendation is in the process of implementation. The possibility of a coordinated public relations program which would involve the AMA, the FMA and the county medical societies is under way.

Recommendation: Allied Health Professions • THAT THE FMA ESTABLISH A MECHANISM WHICH WILL ENABLE THE FMA TO DEAL WITH ALLIED HEALTH PROFESSIONS.

Action • This recommendation has already been implemented with the establishment of an active Committee on Health Manpower. This committee

will be a very valuable resource committee on allied health manpower issues for the FMA leadership and all councils and committees.

Recommendation: GTE-MINET • THAT THE FLORIDA MEDICAL ASSOCIATION PROMOTE THE INSTALLATION AND UTILIZATION OF THE GTE-MINET SYSTEM (COMPUTERIZED MEDICAL DATA BASES AND ELECTRONIC MAIL) WITH THE FMA FIELD OFFICES, COUNTY MEDICAL SOCIETIES, AND SPECIALTY SOCIETIES WITH OFFICES.

Actions • This recommendation has been approved by the Board of Governors and is in the process of implementation. Several systems are already in place and others will soon follow. Instant two-way communication will be available between the FMA and its component county medical societies, and we are eargerly awaiting the completion of the installation.

Recommendation: Financial Report • THAT EACH YEAR AT THE FIRST SESSION OF THE ANNUAL MEETING OF THE HOUSE OF DELEGATES, THE TREASURER PROVIDE A WRITTEN FINANCIAL REPORT TO EACH MEMBER OF THE HOUSE OF DELEGATES, PRESENT A VERBAL EXPLANATION OF THE REPORT, AND RESPOND TO QUESTIONS CONCERNING IT IN THE APPROPRIATE FORUM.

Action • This recommendation has been approved and will be implemented at the upcoming 1985 Annual Meeting.

Recommendation: Medico-Legal Hotline • THAT THE FMA ESTABLISH A MEDICO-LEGAL HOTLINE TO ASSIST PHYSICIANS CONFRONTED WITH POTENTIAL LEGAL DIFFICULTIES.

Action • This recommendation was discussed at length by the Board of Governors. The Board believes that services beyond the provision of a medico-legal hotline would be helpful to the membership. A section will therefore be established within the Medical Economics Department of the FMA to monitor the rapid escalation of alternative health care delivery systems and the impact on the traditional fee-for-service system of health care delivery.

Establishment of this section will be carried out in the most expedient manner possible within the current staff structure of the FMA. A study is also being conducted of the fiscal feasibility of developing a Physician Desk Guide to Florida Law. Staffing of this section in the Medical Economics Department will result in immediate assistance to members of the FMA who have questions regarding the complex legal and contractual problems that are facing them. It should be clearly understood, however, that the FMA cannot assume the responsibility for providing comprehensive legal services to its members. Such services must of necessity be provided by the member's own personal attorney.

Recommendation: Annual Meeting Date • THAT THE FMA MOVE THE ANNUAL MEETING TO SEPTEMBER BEGINNING WITH THE 1987 ANNUAL MEETING; AND FURTHER, THAT CONSIDERATION BE GIVEN TO ROTATING THE ANNUAL MEETING TO ALL FLORIDA CITIES HAVING ADEQUATE FACILITIES.

Action • This recommendation has been approved by the Board and will go to the House in May for consideration. Moving the Annual Meeting to this early fall date would make it possible for the FMA to develop a more timely, effective legislative program. Many of the committees of the Legislature begin their pre-session meetings in late fall. At the present time, the Legislative Session is half over before the House of Delegates has an opportunity to make policy decisions on current legislative issues.

Recommendation: Legislative Program • THAT THE SUCCESSES AND FAILURES OF THE FMA LEGISLATIVE PROGRAM IN RECENT YEARS BE REVIEWED IN ORDER TO DETERMINE THE OVERALL EFFECTIVENESS OF THE FMA LEGISLATIVE PROGRAM.

Action • This recommendation has already been implemented by bringing in outside consultants for a detailed review of the FMA's legislative arm. The results of that study were summarized in my January President's Page. The recommendations contained in the study report are in the process of implementation.

Recommendation: Specialty society representation • THAT EACH SPECIALTY GROUP RECOGNIZED BY THE FMA HAVE A VOTING DELEGATE IN THE HOUSE OF DELEGATES.

Action • This recommendation was based on the report of a special ad hoc committee that indicated that 22 state medical societies now have such specialty representation in their house of delegates. As a bellwether state, Florida is probably in more need of specialty representation than most states if effective decision-making by the FMA House of Delegates is to take place. The Bylaws Committee of the FMA has studied this recommendation and believes that adopting it will in no way interfere with the operation of the House of Delegates. Adequate safeguards to ensure that a specialty society delegate will only have one vote can also be easily achieved.

Because of the complexity of the problems that are facing us at this time, this is one of the most important recommendations to come out of the Programs and Priorities Committee. Concerns about changes in the balance of power in the House of Delegates should not be overriding when the good of all members is at stake.

Recommendation: Specialty society legislative activities • THAT THE FMA CONTINUE ITS EFFORTS TO COORDINATE THE LEGISLATIVE ACTIVITIES OF SPECIALTY SOCIETIES WITH THE FMA LEGISLATIVE PROGRAM.

Action • This recommendation has been approved and the Council on Legislation is now meeting with the leadership of those specialty societies that have legislative problems so as to work out a coordinated strategy in dealing with them.

Recommendation: Specialty society administrative support • THAT THE FMA PROVIDE FULL OR PART-TIME ADMINISTRATIVE SUPPORT TO ALL FMA SPECIALTY SOCIETIES REQUESTING SUCH; AND FURTHER, THAT THE FMA CHIEF EXECUTIVE OFFICER MEET REGULARLY WITH SPECIALTY GROUP STAFFS.

Action • This recommendation has been approved and is now in the process of implementation.

Recommendation: Restructuring of the Board of Governors • THAT THERE BE A RESTRUCTURING OF THE BOARD OF GOVERNORS TO CHANGE IT FROM A PARTIALLY APPOINTED BOARD TO A BOARD WHOSE TOTAL MEMBERSHIP IS ELECTED.

Action • This recommendation has been considered by the Board of Governors and will go to the House of Delegates in the following form: Beginning in 1986, the replacement for the district Board member whose term is expiring will be elected by the House of Delegates instead of being appointed by the President. The same procedure will be followed in each of the three succeeding years so that by 1989 all district Board members will have been elected rather than appointed. At that time, another review of the organizational structure of the Board of Governors will be conducted to determine whether any additional changes should be made or not. The entire composition of the Board will be considered at the March meeting of the Board of Governors.

In addition to these recommendations coming from the Committee on Programs and Priorities, the Board of Governors will be submitting to the House in May a recommendation that a Section on Medical Students and a Section on Residents be established within the framework of the FMA. Establishing these two sections should result in strengthening the membership of the FMA by bringing in young physicians at an early stage in their medical education and professional career.

Additional long range planning will obviously be required and will be done on a timely basis, however, a good start has been made. I express my deep appreciation to Dr. Sanford Mullen, Chairman of the Committee on Programs and Priorities, and to the other dedicated members of the Committee who participated so effectively in the work of the Committee and in the preparation of its report.

Frank C. Coleman MD

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EDITORIAL

Investing in our future

Mitchell Hoffman. Christopher Cunha. Do you know these gentlemen? Some of you do, and you know them as medical students who have demonstrated a desire to be involved in organized medicine in this state. However, I doubt that either one of these young, enthusiastic individuals who feel very strongly about helping to shape the future of medicine on both a national and state level would have had the opportunity to demonstrate their willingness to become involved had it not been for the encouragement given to them by a few FMA members and the "open door policy" of the Florida Medical Association.

Mitch Hoffman was introduced to the Florida Medical Association through his involvement in the design and production of a scientific exhibit for one of our annual mectings. He worked long and hard on the project, and by so doing, learned a great deal about the disease process his exhibit represented. His exhibit won third place that year. In addition to the knowledge Mitch gained by planning, developing, and representing his exhibit, he also became acquainted with the members, staff, and proceedings of our annual meeting. Mitch Hoffman is currently Administrative Chief Resident in Obstetrics and Gynecology at the University of South Florida College of Medicine.

Chris Cunha was appointed student representative to the Board of Governors this year. He has been most active in representing the FMA's policies regarding the future of medicine on both a state and national level to the news media and other medical students. He has also taken an active role as a student representative to the AMA.

There are currently 1487 medical students in our three state medical schools. A prestigious Dean of one of our medical schools spent several minutes at a recent Board of Governors meeting telling us of the quality, ability and character of today's medical students. He was most impressed with their intense desire to become involved in shaping the future of medicine in the State of Florida. The Dean was quite sincere with his praise and admiration for our young physicians-to-be who are entering a profession in which there is considerable change and turmoil. Certainly our medical students are apprehensive and concerned, more so than ever before, about our profession and how their lives and careers will be affected.

Each year the Hillsborough County Medical Association sponsors a dinner meeting whereby the members are asked to invite a student from the University of South Florida College of Medicine to meet the members and get acquainted with organized medicine on the county level. Obviously, not all of us live in a county in which a medical school is located, however, many of us know medical students who are from our hometown or local area and there is no reason why we cannot get to meet them and perhaps even have them spend some time in our offices during breaks and holidays when they are home from their respective schools. Certainly the many FMA councils and committees would be pleased to have members invite a medical student to sit in our respective meetings as an introduction to organized medicine. The Executive Committee and Board of Governors are currently considering revision of policy to expand resident and medical student interaction with the Board.

The medical students of today look to us for guidance and our invitation to become a part of the FMA and organized medicine. Let us give them the opportunity to join us and become involved in our great state association. Think of it as an "investment in our future." You will be pleased that you did: so will they. Just ask Mitch or Chris!

Pierre J. Bouis Jr., M.D.
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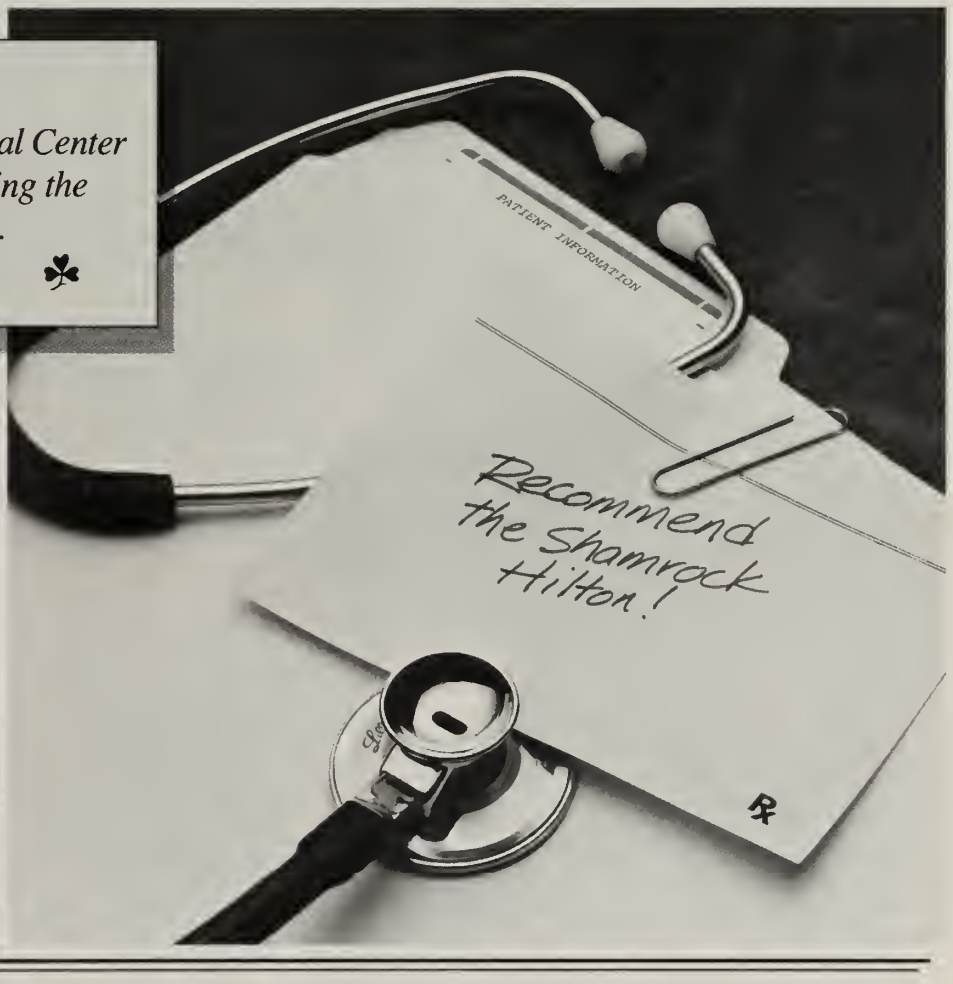
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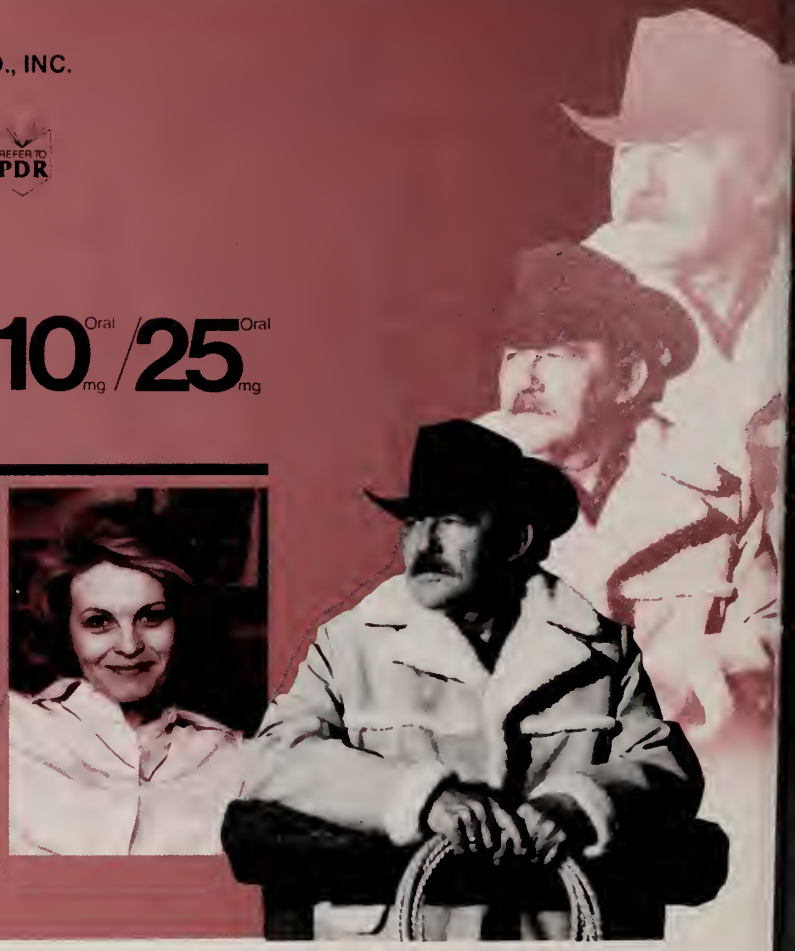
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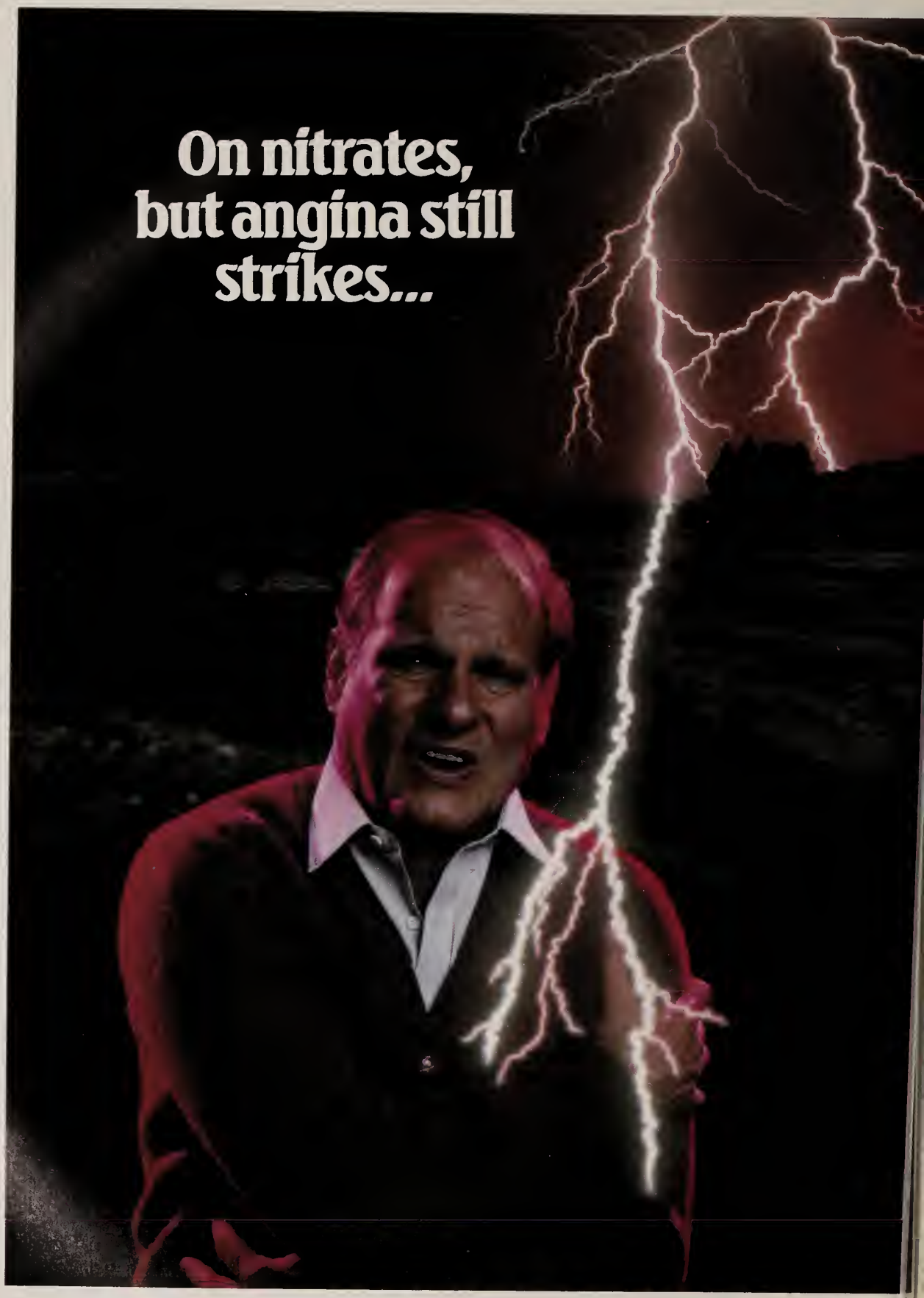
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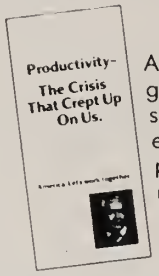
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February 1985, Vol. 72, No. 2

Contemporary surgical management for hepatic metastases of colorectal origin

Kirby I. Bland, M.D.

ABSTRACT: The management of hepatic metastases of colorectal origin requires a systematic approach to therapy. Approximately 5% of patients initiate the decision for resection at the primary operation or with reoperative efforts. With appropriate selection of candidates, five-year survival rates for resectable lesions exceed 20%. Patients in whom diffuse hepatic metastases are evident at the primary or reoperative procedure should be considered candidates for regional chemotherapeutic perfusion. Systemic chemotherapeutic modalities should be considered for progressive disease. The application of CEA and adjunctive diagnostic parameters appears crucial for the identification of individuals with hepatic metastases considered salvageable by surgical resection or use of regional chemotherapeutic perfusion.

The Author
KIRBY I. BLAND, M.D.
Dr. Bland is Professor and Associate Chairman of the Department of Surgery, University of Florida College of Medicine, Gainesville.

Despite aggressive efforts over the past two decades with systemic and regional chemotherapy for hepatic metastases of colorectal origin, minimal benefit has been recognized. Indeed, the best response rates were approximately 20% following systemic administration of 5-fluorouracil (5-FU) in over 2,000 patients.[1,2] The recognized prognosis of hepatic metastases on survival is well documented. The natural history (survival) of patients with untreated hepatic metastases varies from 5.0 months to 21.5 months and depends upon stage (extent) of disease at diagnosis.[3] Clearly, hepatic metastases represent the gravest threat to survival with disease involvement of a single organ and are the most common cause of death from metastases of intraabdominal viscera. While chemotherapy has a definitive role in the therapy of specific metastatic neoplasms, these dismal response rates have stimulated investigators to attempt remissions with the application of regional chemotherapy. This more aggressive approach has had varying response rates in retrospective and propective trials with results favoring the regionally treated subset over the systemic therapeutic group.[4]

Growth and development of liver metastases are dependent on their nutrient blood supply. While micrometastases reach the liver via the portal venous system following invasion of the mesenteric veins (Fig. 1), they obtain their initial blood flow from the portal vein with replacement of nutrient blood supply primarily from arterial neovascularization as the metastases enlarge. Thereafter, liver metastases, which represent the greatest threat to survival, are observed in one third to one half of patients having recurrent colorectal carcinoma. Cedermark et al[5] and Bengmark and Hafstrom[6] have estimated that as many as one half of all primary tumors

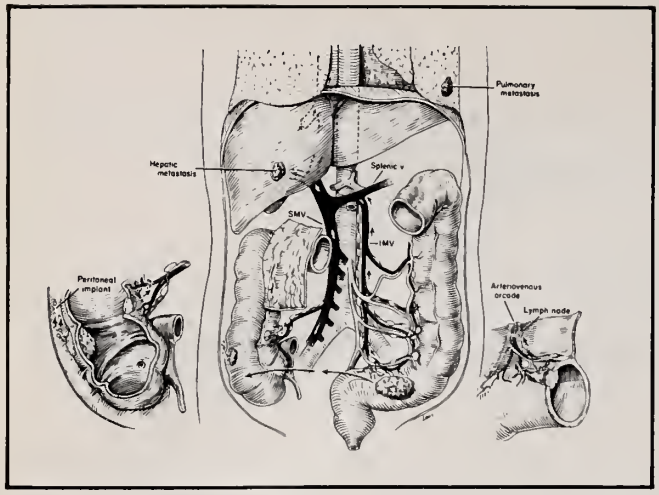


Fig. 1 — The mechanism of micrometastases of colorectal carcinoma. Venous and lymphatic routes of dissemination are evident with survival of the metastatic cells in hepatic parenchyma following reestablishment of nutrient blood supply. Bland, K.I.: Reoperations for Primary and Secondary Neoplasms of the Gastrointestinal Tract. In Fry, D.E. (ed): Reoperative Surgery of the Abdomen (for: Science and Practice of Surgery by Morris/Burke), Marcel Dekker, Inc., N.Y., in press.

drained by the portal system give origin to hepatic metastases. These authors observed an incidence of synchronous liver metastases at laparotomy for almost one fourth of the patients and projected a mean survival time of 5.7 months.

Diagnostic approaches to establish hepatic metastases • The suspicion of liver metastases often follows physical examination corroborated with chemical laboratory testing of hepatic functions, liver scintography, sonography, or a combination thereof. Radionuclide scanning provides an overall accuracy approaching 80% with diagnostic ultrasonography and radioimaging allowing a similar accuracy.[7] Computed tomography complements ultrasonography and represents "state of the art" investigation of all hepatic lobes. Second and third generation scanners and nuclear magnetic resonance (NMR) should allow detection of lesions less than 1 cm in diameter. Hepatic angiography of the celiac and hepatic arterial distribution should be performed to evaluate tumor extent and to precisely document hepatic arterial and venous blood flow prior to the planned resection.

Operative and reoperative approaches for hepatic metastases • The early experience of Woodington and Waugh[8] for resection of hepatic metastases from various visceral cancers noted a 20% five-year survival rate with an acceptable operative mortality (4%). Wilson and Adson[9] reevaluated operative intervention for secondary liver neoplasms of primary colorectal origin from 40 patients having solitary lesions. Fewer candidates were eligible for resection of multiple lesions although operative mortality was acceptably low (1.7%). No patients with multiple secondary lesions excised lived five years, whereas, of 54 patients eligible for five-year survival analysis, 15 (28%) lived five years or more and eight (15%) were alive without evidence of recurrent disease at ten years or greater. Thus, it would appear that aggressive surgical therapy for apparent solitary hepatic metastases of colorectal origin is justified on the basis of the survival rate of selected patients.

Attempts at wide and total macroscopic excisions of "inoperable" neoplasms have shown that while complete resections often cannot be accomplished, prolonged survival has nevertheless been achieved in certain circumstances. These observations suggest that there is some degree of host resistance operative for microscopic foci of residual tumor. Synchronous hepatic metastases are noted in 10-30% of patients at the time of laparotomy initiated for resection of primary colonic neoplasm. Nonetheless, approximately one fourth of these patients are considered to have "resectable" secondary liver tumors as defined by a solitary nodule or mass limited to a single lobe or segment which is amenable to operative intervention. While controlled and uncontrolled trials of chemotherapy may prolong survival for an additional few months, interpretation of these studies is difficult. Survival longer than two years after demonstration of metastatic disease is unusual, with essentially all five-year survivors of biopsy-proven hepatic metastases from primary colorectal carcinomas have had resection of secondary lesions.

Table 1 summarizes the collective series of hepatic resections which have been initiated at synchronous and metachronous intervals for metastatic colorectal carcinoma. One should recall that these patients are highly selected and, as Foster[3] suggests, would in all probability have had a more favorable prognosis than the usual patients with liver metastases even if left unresected. Of 579 patients, 421 were at risk for five-year analysis. Approximately one fifth of the total series lived less than two years following operative treatment of the secondary lesion. When absolute survival is calculated, 178 patients (42.3%) lived 2-5 years, whereas 98 patients (23.2%) lived 5-10 years and 13 patients (3.1%) ten or more years as calculated from the entire series. Thus, selective patients can benefit by this aggressive approach.

In their analysis of the 1974 liver tumor survey (LTS) for resection of metastatic tumors of extrahepatic origin, Foster and Berman[10] observed 62 pa-

tients undergoing synchronous and 64 undergoing metachronous resections for metastatic colorectal primaries. Of 88 patients available for five-year survival analysis, 16 (18%) were alive 60 months following resection (Table 2). Foster and Berman observed that 20% of 45 patients at risk with resected solitary lesions and 24% of 29 patients with resected multiple metastases of bilobar or unilobar origin lived five years. Statistical analysis of these subsets discloses no difference between the operative groups with regard to five-year survival. These authors also noted that prognosis was not significantly affected by the presence of more than one tumor nodule unless multiple metastases were evident in both anatomical lobes. An update of this analysis by Foster[3] with combination of collective reviews with the LTS and the author's experience noted 259 patients considered survivors of liver resection for metastatic colorectal cancer. In subsequent analysis, Foster[11] observed 162 patients at risk for five years in this series in which a 30% five-year survival rate for resected solitary lesions was compared with a 13% five-year survival rate for individuals having resection for multiple hepatic secondary lesions. This analysis of the time interval between resection of the primary colorectal cancer and resection of the hepatic metastases suggests that a prolonged disease-free interval has a modest to negligible benefit on prognosis after liver resection for secondary cancer, and that a period of observation for disease progression is unwarranted (Table 3). These data suggest that survival after synchronous resection is essentially identical to that for metachronous resection when the interval from resection of the primary neoplasm exceeds two years. Further, Foster inferred from this cumulative review that subsequent survival does not correlate with the status of the mesenteric nodes at primary colon neoplasm resection nor with the extent (volume) of liver parenchyma resected. Conversely, the number and size of the secondary hepatic tumors do correlate directly with curability by resection.

Statistically, one fifth of the patients with primary colorectal cancer have metastatic hepatic disease of which one fourth of these secondary lesions are solitary or unilobar. Thus, approximately 5% of patients with secondary hepatic lesions will initiate the decision for reoperation and potential resection. Additionally, approximately 50% of the latter patients will have undetectable metastases at exploration. While the evidence would strongly favor the decision to initiate hepatic resection whenever limited solitary or unilobar disease is encountered, this

Table 1. — Collective Series of Hepatic Resections for Metastatic Colorectal Cancer.

Author	Number Patients	Patients at Risk For 5-year Analysis	Lesion(s) Resected Multiple	Lesion(s) Resected Solitary	Operative Mortality	Absolute Survival (yr) < 2 No. (%)	Absolute Survival (yr) 2-5 No. (%)	Absolute Survival (yr) ≥5 No. (%)	Absolute Survival (yr) ≥ 10 No. (%)
Wilson and Adson	60	54	20	40	1 (1.7%)	18 (33)	13 (24)	15 (28)	8 (15)
Foster and Berman	126	88	45	81	8 (6.3%)	36 (41)	36 (41)	16 (18)	--
Foster[2] (1978)	259	206	--	--	13 (5.0%)	--	84/192 (44)	46/206 (22)	--
Wanebo et al (1978)	27[1]	25	2	25	2 (7.0%)	4 (16)	14 (56)	7 (28)	--
Fortner et al (1978)	25	2	11	14[3]	2 (8.0%)	9 (39)[3]	12 (52)	2 (9)	--
Adson and Van Heerden	34	3	11	23	2 (5.8%)	7 (22)	18 (56)	4 (13)[3]	3 (9)
Morrow et al (1982)	29	29	1	28	NA (20%)[4]	19 (66)	--	8 (27)	2 (7)[3]
Logan et al (1982)	19	14	7	12	1 (5.3%)[4]	7 (37)	8 (42)	4 (21)	--

[1]1974 Liver Tumor Survey (LTS), survival data calculated on 88 patients at risk ≥ 5 years.
[2]Collective review + LIT + author's experience.
[3]Extrapolated from survival data; excludes operative deaths.
[4]Includes operative mortality of series.

Modified from Bland, K.I. and Polk, H.C. Jr: Therapeutic Measures Applied for Curative and Palliative Control of Colorectal Carcinoma. In Nyhus, L.M. (ed.): Surgery Annual, 1983, pp. 145, Copyright 1983 by Appleton-Century Crofts, E. Norwalk, Connecticut.

Table 2. — Resection of Metastatic Cancer — 1974 LTS: Primary Colon and Rectum, Solitary or Multiple Lesions vs Survival.

	Metastasis		
	Solitary	Multiple	
		Unilobar	Bilobar
Patients	81	30	15
Operative deaths	1	3	4
Mean survival[1]	29 months	40 months	19 months
Median survival[2]	16 months	16 months	14 months
5-year survival	9/45 (20%)[2]	6/19 (31%)[2]	1/10 (10%)

[1]Excludes operative deaths.
[2]p = NS.

From Foster, J.H., Berman, M.M.: Solid Liver Tumors, Major Problems in Clinical Surgery, Volume XXIII, 1977, Copyright by W.B. Saunders, Philadelphia.

decision must be tempered by the judgment that the primary intestinal neoplasm is controlled without evidence of distant spread of disease. Further, the technical expertise and experience of the surgeon, availability of anesthesia and blood as well as the patient's general medical status must be considered. Certainly, hepatic angiography should precede any technically resectable hepatic lesion. Finally, the experience of Foster and Berman[10] does not support total lobectomy as a preferred procedure over simple excision or wedge resection of the primary lesion in which an adequate margin of normal liver encompasses the resectable neoplasm.

Operative approaches for the delivery of regional chemotherapy for unresectable hepatic metastases • We have witnessed extensive efforts over the past two decades to improve response rates of metastatic hepatic neoplasms with the delivery of intraarterial chemotherapy (HIAC). The rationale for employing HIAC is the aggressive attempt to improve antitumor drug effect with the introduction of a delivery system which provides concentration of the chemotherapeutic agent in the hepatic tumor relative to drug exposure of dose-limiting sensitive tissues in other sites (gastrointestinal epithelium, myocardium, bone marrow, etc.).[12] Three essential aspects for the successful delivery of HIAC have recently been reviewed by Ensminger and Gyves[13] and include: (1) operative catheter placement to appropriately infuse drugs to the entire liver and the hepatic neoplasm, (2) use of tumor-sensitive drugs, and (3) utilization of a system which allows repeated and chronic administration conveniently, reliably and, preferably, in the outpatient setting.

The past decades have witnessed varying response rates in institutions which utilize intraoperative placement of catheters or use of angiographic catheters by the percutaneous Seldinger technique.[12] These variations of route and schedules for drug

Table 3. — Colon and Rectum Primary: Interval Between Bowel and Liver Resection.

		Metachronous	
	Synchronous	Less Than 2 Years	More Than 2 Years
Number Patients	111	60	69
Mean survival (mo)[1]	27	26	34
2-Year survival[1]	43/88 (49%)	25/50 (50%)	19/56 (34%)
5-Year survival[1]	15/81 (19%)	12/47 (26%)	10/51 (20%)

[1]After liver resection; excludes operative death.

From Foster, J.H.: Treatment of Metastatic Cancer to Liver. In DeVita, V.T. Jr. et al (eds): Cancer Principles and Practices of Oncology, 1982, J.B. Lippincott Company, Philadelphia.

delivery have been recently reviewed[4] and, as suggested, therapeutic subsets were favored over control or systemically treated groups. Several investigators[14-16] reported that 95% of the neoplastic blood supply arose from the hepatic artery, whereas a nominal 5% of the nutrient blood flow arose from the portal vein. However, prior to the past four years, morbidity incurred with the placement of angiographic catheters was extensive and included catheter dislodgement, arterial and venous thrombosis, embolization, bleeding, and infection. Oberfield et al[17] reported complication rates as high as 80% and included variations of the aforementioned problems, the most important being malperfusion of the metastatic hepatic tumor as a result of abnormal arterial anatomy (variations in the celiac axis, replaced right hepatic artery, etc.). While operatively-placed catheters provide a reduction of these complications, they were seldom patent beyond six months as a result of arterial or catheter thrombosis and/or dislodgement. Pioneering efforts of Buchwald et al[18] and Niederhuber and Ensminger[19] were apparent following introduction of the Infusaid® pump (Metal Bellows Corporation, Norwood, MA) and abrogated the major concerns of catheter dislodgement and function and, importantly, avoided the necessity of patient restriction to the hospital associated with the use of HIAC. The Infusaid® pump is a totally implantable, percutaneously refillable device powered by charged freon which has a 50 cc reservoir driven at a set rate (3.6 ml per day) with refill requirements every eight to 16 days on an outpatient basis. Ensminger et al[20] reported the experience in 13 patients with metastatic hepatic neoplasms of which 11 were of colorectal origin. The reliability of the Infusaid® pump with consistent flow rates was observed over 2,800 cumulative days with only one malfunction. Partial or complete regression of hepatic tumor was observed in nine patients (82%) with colonic primaries when documented by physical examination and radionuclide liver scans. A subsequent report by Niederhuber and Ensminger[19] documented over 20,000 cumulative days of infusion in 96 individuals, over 95% of whom were treated as outpatients. Major drug toxicity included anicteric (46%) and icteric (23%) chemical hepatitis, mild gastritis (60%), and ulcers (8%) as a result of the 5-FUDR infusate. Operative mortality was experienced in 2%, with morbidity from pump- and catheter-related problems observed in 16%. Niederhuber and Ensminger note that tumor response was excellent (83% partial response rate) with extension of survival. A notable observation by these authors was that the majority of nonsurvivors were dying of neoplasm metastatic to remote organ sites rather than of hepatic failure which has been historically the greatest single organ site for mortality.

These observations have subsequently been confirmed by Balch et al[21] with a report of 50 consecutive patients with metastatic colorectal carcinoma. Follow-up in this report was a median time of six months. These authors have observed a remission rate of 83% for the evaluable patients with a decrease in the CEA level by 80% (range 35-97%). Tumor progression was evident in only 4% of patients who initially had a good response as documented objectively by follow-up scans and CEA values, whereas 14% had relapse in extrahepatic sites (pelvis, lung and bone).

Our experience has been limited to the Model 400 Infusaid® pump. Over the past 26 months, we have operated on 36 patients with known hepatic metastases of whom 13 (36%) were considered ineligible for pump placement on the basis of the intraoperative findings of extrahepatic disease. Of the 23 patients, 22 were implanted for metastatic colorectal carcinoma and one for cholangiocarcinoma. The absolute and relative contraindications for placement of the Infusaid® pump follow:

Absolute

1. Histologic and/or radiographic evidence of remote organ involvement distant to perfused site, e.g., extrahepatic — lung, bone regional, etc.
2. Ascites
3. Nutritional compromise (> 15% of body weight)

Relative

1. Hepatitis — cirrhosis
2. Hyperbilirubinemia (> 5 mg%)
3. Gastric/duodenal ulcer disease
4. Advanced cachexia-limited survival
5. Remote sepsis
6. Compromised/replaced hepatic arterial anatomy

Among the previously mentioned patients, 24 pumps were placed, as one patient required a dual system on the basis of replaced hepatic arterial anatomy. Major complications included gastritis (44%), cholecystitis (19%), and pseudoaneurysm of the gastroduodenal artery (4%), with an overall morbidity rate of 67%. Three patients (13%) required replacement of the pump due to two malfunctions and a leak at the catheter outflow port. We have noted a 56% overall objective response rate (complete and partial) in 13 patients demonstrated by reduction of tumor mass on computed tomography or decrease in liver function values and the CEA. Two complete and 11 partial responses were noted. No deaths have been observed in follow-up over 26 months (range 4-26 months, median 14.0 months).

Perspectives to the approach of hepatic metastases • An estimated 10-20% of patients with primary resectable colorectal neoplasms have overt (synchronous) hepatic metastases of which less than one half (5%) are resectable.[22] Finlay et al[23] observed that hepatic metastases were detected in 14% of 43 consecutive patients undergoing laparotomy for colorectal carcinoma. Twenty nine percent of patients undergoing apparent curative resection for colorectal carcinoma, who were considered to have a disease-free liver at laparotomy, subsequently developed hepatic metastasis during a two-year follow-up interval. Thus, these occult hepatic metastases are deserving of interval follow-up which may necessitate hepatic resection at metachronous intervals. We routinely screen in follow-up with interval CEA and liver function tests every one to three months, and perform computed tomography of the abdomen and liver with chest x-ray every six months. Further, in an effort to identify metachronous primaries of the colon, the performance of a baseline barium enema with restudy on an annual basis appears justifiable following curative resection of colon lesions above 25 cm. Additionally, the use of occult blood analyses (guaiac vs Hematest®) appears justifiable every two to three months for one year, every three months for the second year, every six months for the third year, and annually thereafter.[24]

For resections with anastomosis below 25 cm, proctosigmoidoscopy is substituted as the main diagnostic parameter in follow-up. Occult blood follow-up is recommended after abdominoperineal resection, with frequency of the test similar to that performed for lesions above 25 cm. We also recommend biopsy in individuals presenting with pain in the perineum following abdominoperineal resection. Furthermore, patient education for examination of the perineum and regional inguinal nodes at risk is important.

The application of diagnostic and therapeutic colonoscopy enhanced clarification of questionable radiographic findings in the majority of patients (89%) studied by Knutson and Max.[25] Overall, the frequency of detecting occult lesions (19%) combined with a substantial reduction in laparotomy-colotomy procedures required for removal of colon polyps (88%) provided a low morbidity (3%) and a low false-negative examination rate to establish the efficacy of this definitive diagnostic modality.

Figure 2 summarizes a logic approach following the confirmation of intraoperative disease status of the liver and abdominal viscera. Synchronous metastases observed in the liver at the primary operation are managed as described under the operative management of hepatic metastases of colorectal origin. Clearly, solitary unilobar lesions amenable to hepatic lobar or wedge resection should be managed surgically if a margin of normal hepatic parenchyma can be resected to allow an NED status. For circumstances in which progressive or recurrent disease in the absence of extrahepatic involvement is evident, placement of the Infusaid® pump is recommended. Nonresponders or individuals in whom recurrences develop in viscera remote from the liver are thereafter treated on protocol with systemic chemotherapy. In all situations in which extrahepatic disease is evident at exploratory laparotomy, an absolute contraindication for pump placement exists and should be extended with findings of ascites, nutritional compromise, hepatitis and/or cirrhosis.[19,26] The success in treatment of diffuse hepatic metastases considered unresectable for cure is often measured in terms of partial response rates, reduction of hospital patient days, and prolongation as well as quality of survival. Niederhuber et al[26] have observed a 68% survival rate for individuals with hepatic involvement alone (18-24 months) in contrast with a 35% survival (8-10 months) for individuals presenting with hepatic and extrahepatic disease. Clearly, a delivery system with the advantage of total implantation, simplicity and reliability of maintenance, and opportunity for usage in an outpatient setting represents a great technical achievement. Patient compliance following placement of the Model 400 system appears good to excellent. Future modifications are being directed at miniaturization of the pump with enlargement of the drug reservoir system to decrease frequency of refill. Finally, therapeutic approaches which utilize more active drugs or additional drug combinations with 5-FUDR are being refined and may allow substantial progress in regional chemoperfusion of hepatic metastases to augment the palliative responses reported previously.

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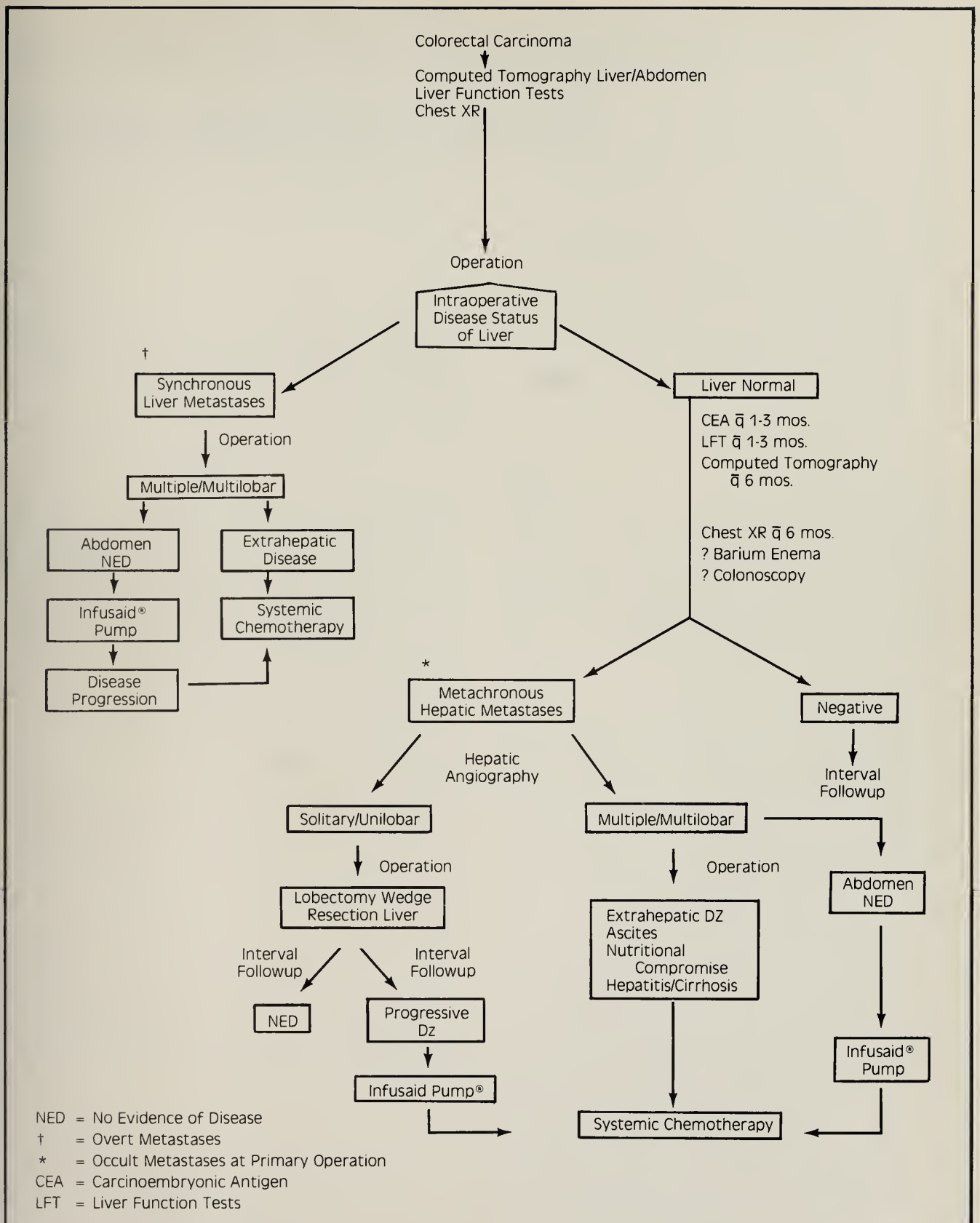


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Presentation of hemophilia A in the newborn period

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ABSTRACT: We evaluated if tumor cell lines which metastasize via different routes vary in their ability to stimulate platelets. We examined three tumor cell lines, null cell acute leukemia (NALM 16), neuroblastoma (NB 100), and B 16 melanoma cells on tumor cell-induced platelet aggregation and thromboxane A_2 (TXA_2) generation. Human platelet-rich plasma (PRP) samples were incubated with tumor cells prior to stimulation with ADP or epinephrine in threshold (T) or subthreshold (ST) concentrations. TXB_2 was measured by RIA in PRP aliquots as index of platelet TXA_2 generation. B 16 melanoma cells induced platelet aggregation and potentiated platelet aggregation in response to ST or T concentrations of ADP or epinephrine. These results were similar for high or low metastatic variants. Neuroblastoma and leukemia cells did not affect platelet aggregation. Melanoma cells increased TXA_2 generation from unstimulated or stimulated platelets (unstimulated: +110%, epinephrine (ST): +100%, ADP (ST): +43%, whereas neuroblastoma and leukemia cells had no effect on platelet TXA_2 generation. These data indicate that tumors which metastasize by certain routes may stimulate platelet aggregation and TXA_2 generation to a greater extent than others.

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Hemorrhage in the newborn period may be due to many causes including thrombocytopenia, vitamin K deficiency, disseminated intravascular coagulation, and hemophilia. Correct diagnosis is important in order to control hemorrhage and for later management. We describe a patient with subgaleal hematoma as an unusual presentation for hemophiliod disorder.

Report of case • A one-day-old white male infant was transferred to Shands Hospital at the University of Florida College of Medicine for enlarging head circumference, bleeding, and hypovolemic shock. He was the 4550 gram 40 week product of an uncomplicated pregnancy, born to a 28-year-old gravida 1, para 0000 female. Labor lasted four hours, and membranes were ruptured two hours prior to delivery. Fetal heart rate was 120/min during labor. Apgar scores were 6 to 8 at one and five minutes respectively. The child was delivered by Cesarean section because of cephalopelvic disproportion. There was no family history of bleeding problems.

At the time of delivery, bruising and molding over the right parietooccipital area was noted, but no fracture was present. Vitamin K oxide, 1 mg, IM was given. A small hematoma resulted several hours later. Several hours after birth, the neonate was noted to have mottled skin, periodic apnea, and a poor suck. Laboratory test results showed hemoglobin 11 g/dl, hematocrit 33.5%, white blood cell count 22,300/cu mm with 42% neutrophils, 12% bands, 30% lymphocytes, 14% monocytes, 1% eosinophils, and 1% metamyelocytes. The platelet count was 163,000/cu mm. At nine hours of age, analysis of arterial blood gas on room air revealed pH 7.19, pCO_2 16.5 mm, and pO_2 122 mm. The neonate was incubated because of respiratory distress. Blood cultures were

drawn and the patient was started on ampicillin and gentamicin. Subsequently, blood cultures showed no growth. The infant was stabilized with infusions of packed red blood cells and fresh frozen plasma.

On arrival at Shands Hospital, the infant was pale and in moderate distress. Temperature was 37.7 C, respiratory rate 40/minute, heart rate 140/minute, and systolic blood pressure 44 mm Hg. Abnormalities on physical examination included 3+ pitting edema over the right parietal area and a markedly swollen right eye.

Initial laboratory studies were done at four hours of age. Hemoglobin was 8 g/dl, hematocrit 23%, and platelet count 150,000/cu mm. Serum electrolytes and calcium were within normal limits. The serum urea nitrogen concentration was 28 mg/dl, creatinine 3.5 mg/dl, and total bilirubin 0.5 mg/dl.

Skull series revealed overriding of the sutures in the lambdoidal and sagittal regions as well as soft tissue swelling. Cranial ultrasound revealed no intraventricular, intracerebral, or subarachnoid hemorrhage. Hematoma and scalp edema were evident. Computed tomography of the head was remarkable for a soft tissue hematoma in the right frontoparietal area outside the skull.

During the next six days, the neonate required six transfusions of packed red blood cells. His platelet count dropped to 77,000/cu mm. The prothrombin time (PT) was 11.0 seconds (control 11.4 seconds), partial thromboplastin time (PTT) 69 seconds (control 25 seconds), and fibrinogen 403 mg/dl (normal 170 to 400 mg/dl). Following two infusions of fresh frozen plasma (each 10 cc/kg), the PTT decreased to 42 seconds.

At ten days of age, the umbilical stump separated from the skin and further bleeding occurred. The bleeding continued despite direct pressure but subsided after placement of a suture, vitamin K (5 mg, IV), and fresh frozen plasma.

At this time the diagnosis of hemophilia or other hemophiloid disorders was considered. Analysis of coagulation factor VIII revealed 2.2% activity while levels of other factors were within normal limits. The patient was therefore diagnosed as having hemophilia A.

Comment • This patient's presentation stresses the need for a high index of suspicion of hemophilia in a newborn with hemorrhage. Most infants with hemophilia do not have bleeding episodes in the neonatal period despite birth trauma.[1, 2] The reason for the lack of bleeding episodes during the first few days of life in most patients with hemophilia A is not known but may be related to intact extensive system of coagulation.[3] Maternal factor VIII does not cross the placenta and, therefore, does not protect the neonate.

In one study in which 192 patients were retrospectively analyzed, only 8% of severely affected patients and 2.5% of less severely affected patients had a major hemorrhage in the neonatal period.[1] Cephalohematomas, umbilical bleeding, and bleeding from heel prick, circumcision, or intramuscular injection were the usual causes of bleeding.[1]

Scalp hemorrhage was especially uncommon and has been reported as a presenting sign of hemophilia in only seven neonates,[1, 4-6] two of whom were born to the same mother.[4] All of these neonates were anemic because of hemorrhage and some suffered from shock and hyperbilirubinemia. Subgaleal hemorrhage, as in the neonate reported here, may be more serious than subperiosteal hemorrhage because of the greater space into which blood can accumulate.[5, 6]

Neonates presenting with prolonged PTT in the presence of normal PT, despite receiving vitamin K, need to be fully evaluated for deficiency of coagulation factors so that the proper therapy can be readily instituted. Physicians should have a high index of suspicion of hemophilia in any infant presenting with hemorrhage.

Acknowledgment

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Fracture of humerus from muscular violence: case report

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ABSTRACT: Fracture of the humeral shaft secondary to muscular violence is a preventable injury. Team physicians must exert a strong influence to prevent strenuous throwing before proper technique is learned. An illustrative case is reported.

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Reports of fractures of the humeral shaft secondary to muscular violence appear occasionally in the literature. The purpose of this presentation is to report a case and to stress the importance of proper throwing technique.

Case Report — On August 18, 1978, during a game, an 18-year-old professional baseball pitcher threw an overhand fast ball, experienced sudden sharp pain in his pitching arm and he collapsed to the ground. He was taken to a hospital emergency room. The radiographs (Fig. 1A, B) revealed a long spiral fracture of the humeral diaphysis with a large butterfly fragment. Treatment by means of a hanging cast was instituted (Fig. 1C, D). The radiographic appearance of the humerus (Fig. 2A, B) on September 25, 1978 revealed callus formation and apparent early union. Within three months of onset of fracture he was throwing a baseball again. Nineteen months postfracture the radiographs (Fig. 2C, D) revealed union of the fracture. When last seen four years postfracture, he was continuing his baseball career with the goal of major league status. He had full motion in the right shoulder and elbow.

Discussion • In 1959 Bingham[1] collected ten reports from the literature on fractures of the humerus resulting from musculature violence and added four cases of his own. The majority of injuries occurred in baseball games with the throwing of a javelin also reported. The reports of Bøje[2] in 1942 and Petersen[3] in 1970 advocated stress as the etiologic mechanism of these fractures.

Arfwidsson in 1957 reported three humeral fractures from hand grenade throwing.[4] He postulated that in fractures of this type the kinetic energy of the limb is a factor of importance and, in addition to the purely active forces, the passive braking effect of the antagonist should be borne in mind. He further suggested that cold and fatigue might also impair the coordination of movements. In his three cases the fractures occurred on throws six, eight, and ten.

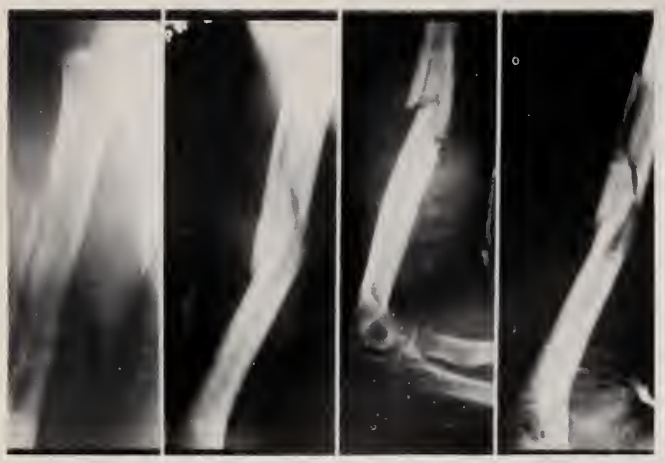


Fig. 1. — A. AP - August 18, 1978; B. Lateral - August 18, 1978; C. Lateral - August 18, 1978; D. Oblique - August 18, 1978.



Fig. 2. — A. September 25, 1978; B. September 25, 1978; C. March 20, 1980; D. March 20, 1980.

He further postulated that the condition of the muscles was an important factor in the fractures. He believes that muscular coordination is improved by practice of the movement involved, which should lessen the danger of fractures in throwing of this type. In his three patients ages 20 and 21 years, hand grenade throwing had been practiced for a maximum of five to six months with total throws of 70 in two and 100 in one.

While research results on warm-up are conflicting, most coaches and athletes seem to believe that warm-up is valuable. Jensen[5] who has coached and taught physical education supports its value.

Peltokallio, Peltokallio, and Vaalasti[6] reported humeral fractures in two Finnish baseball players and in one javelin thrower. Their patients were amateur athletes who played regularly. They proposed a faulty throwing style as the main probable cause of this fracture. They say that a "round arm" style in which the arm spreads too far on the side during the throwing act exerts a heavy strain on the arm. In the extreme, the brachium may be nearly parallel to the ground and the elbow flexed to a right angle. In this style, marked internal rotation of the arm occurs early in the throwing process and a very heavy strain is exerted on the elbow joint and on the humerus itself.

Chao, Miller, and Teng[7] reported 129 spiral humeral fractures in military recruits in Taiwan from 1959 to 1966 in the Republic of China Army. The age spread was 19 to 33 years, 88% occurring in the 20 to 24 year group and 95.3% in the distal third of the humerus. These authors suggest that the torsional force results in an unbalanced dynamic equilibrium of forces acting on the humerus. They constructed a simulator to study the mechanics of the grenade throw. Using the studies of Halliday and Resnick[8] (Table 1) $F = MA = M(V/T)$ and $FT = MV$ they defined torsional force without a grenade as: $F_1T = M_1 V/T = M_1A$. The torsional force with the grenade was defined as: $F_2T = (M_1 + M_2) A$.

The velocity of the forearm and time of application of the force are assumed to remain effectively constant for both conditions.

They used a grenade weighing 22 ounces (625 grams.) They determined experimentally that the time of application of the torsional force was effectively equal to 0.1 second, and that a torsional force approximately 7 foot pounds applied at the distal end is sufficient and necessary to cause a spiral fracture of the humerus occurring in the distal third of the bone.

Gregersen[9] collected four cases, two in soldiers throwing hand grenades and two in handball players making a violent throw. He attempted to analyze the mechanism of the injury and concluded that at the point of throw when external rotation changes to internal rotation and when flexion of the elbow changes to extension, the torsional force acting on the humerus is at its maximum and it is at this point

Table 1. — Halliday and Resnick define torsional force.

F	=	Force
F_1	=	Force torsional without grenade (ft lb)
F_2	=	Force torsional with grenade (ft lb)
M	=	Mass (lb)
M_1	=	Mass of forearm (lb)
M_2	=	Mass of grenade (lb)
V	=	Velocity of forearm or forearm grenade aggregate (ft/sec)
A	=	Acceleration of forearm or forearm grenade aggregate (ft/sec)
T	=	Time of application of force (sec)
FT_2	=	is apparently greater than FT_1 Consequently, a fracture can be more reasonably expected when a hand grenande mass is thrown

that fracture occurs. Further he postulated two predisposing factors to this injury: first, uncoordinated muscle action occurring when external rotation is not completed before internal rotation starts; second, an incorrect throwing technique in which the upper arm is too violently abducted with inadequate flexion of the elbow. He stresses that to achieve a correct throw, there must be simultaneous movement of the trunk and lower limbs with the feet correctly positioned and the body twisting. In the over-arm throw the arm moves violently forward and upward from the externally rotated position in adduction, with extended elbow and shoulder. Then the elbow is flexed to a maximum of 90 degrees halfway through the throw. As the end of the throw is reached the arm has passed the vertical position, the elbow is suddenly extended, and there is at the same time a sudden internal rotation of the arm, immediately after which the missle is released. He stresses that if the muscle action becomes uncoordinated, internal rotation of the arm may start before external rotation is complete; the chance of fracture increased. The amount of torsional stress applied to the humeral shaft during the throw depends on the missle weight (javelin 800 grams, baseball 200 grams, and hand grenade 700 grams).

Krishnamurthy[10] reported a 14-year-old boy who sustained a spiral fracture of the humerus with a butterfly fragment while throwing a snowball. McLearie[11] reported a 27-year-old man who sustained a comminuted spiral fracture which occurred as a cricket ball was delivered. Neither patient had radiological evidence of pathology.

All fractures in the publications reviewed occurred in a humerus in which there was no radiological evidence of disease. Torsion on the humeral shaft appears to be an important factor. Uncoordinated muscular activity appears to increase the likelihood of fracture. Javelin and hand grenade throwing are overhand activities. Peltokallio and associates[6] suggest that a sidearm throw increases the torsion of the humerus. It seems probable that sidearm pitchers would be at greater risk than overhand pitchers.

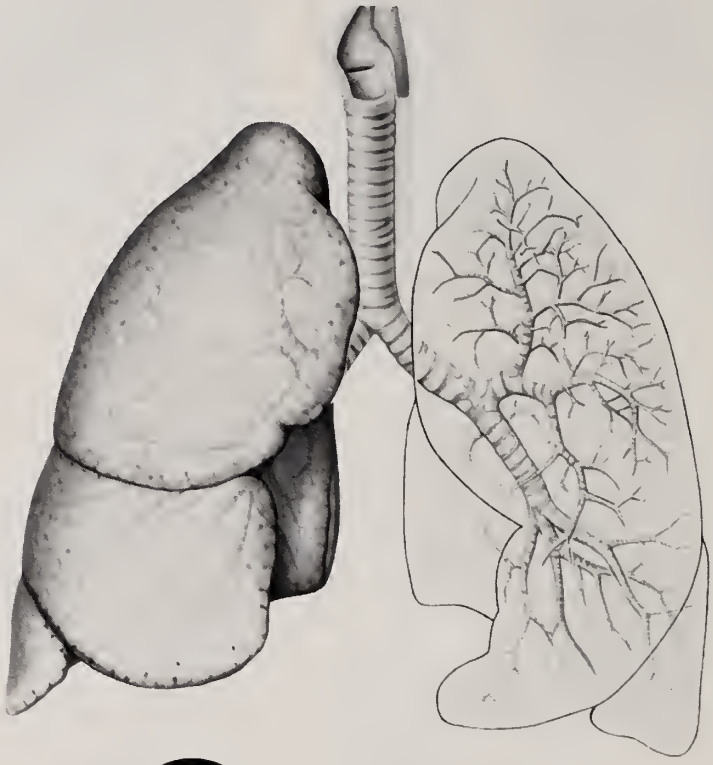
Fractures of the humeral shaft from muscular violence is a preventable injury if proper throwing technique is used. Proper overhand throwing technique prevents excessive torsion on the humeral shaft. Excessive torsion will occur when internal rotation of the humerus starts prior to allowing maximum external rotation to occur. When this happens the throw is not coordinated. Since proper warm-up times and pitching frequencies are not well established, uncoordinated throwing should be watched for as a sign of a too short warm-up period or fatigue of the pitcher.

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Indications and Usage Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

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Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions *General Precautions* – If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made, because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy – Pregnancy Category B – Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly). There are, however, no adequate and well controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers – Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children – Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain – Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic – Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

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Renal – Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(061782R)

Note Ceclor® (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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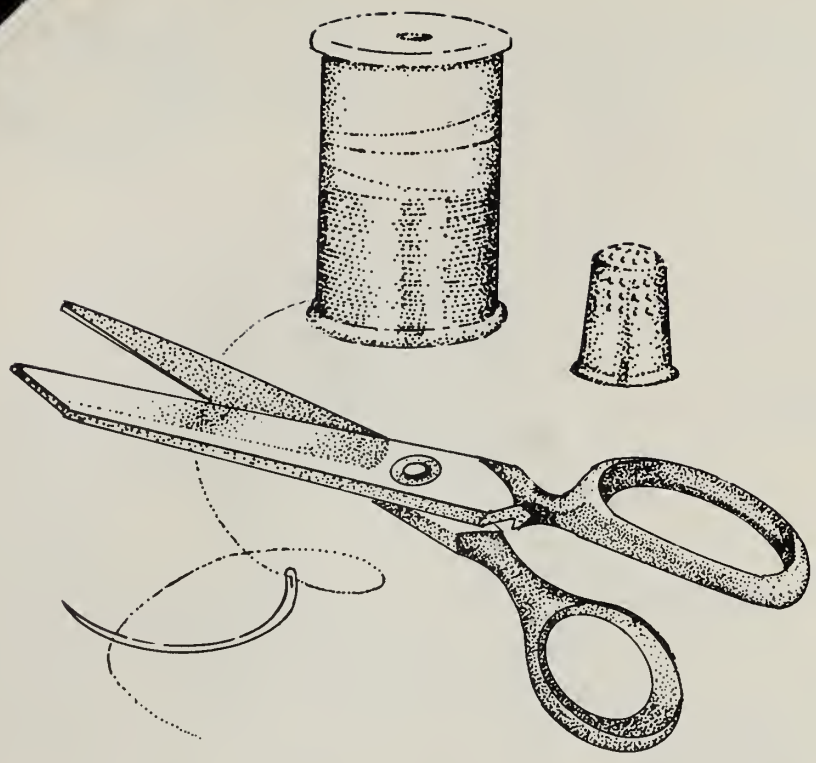
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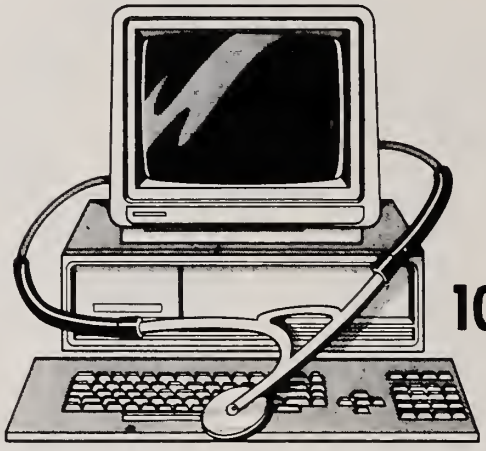
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References:
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Prehistoric syphilis in Florida

M. Yaşar İşcan, Ph.D., and Patricia Miller-Shaivitz, B.A.

Treponematoses, including venereal syphilis, are diseases that are controversial in origin and distribution. Three theories have been proposed about the origin of syphilis: Columbian, pre-Columbian, and Unitarian.[1,6] The Columbian theory proposes that syphilis was brought to the Old World from the New World. The pre-Columbian theory states that syphilis was present in the Old World long before the return journey of Christopher Columbus. The Unitarian theory claims the disease agent was present on all continents, i.e., that the treponemal organism was able to produce various pathologic responses under specific socioenvironmental conditions.

There is evidence of syphilis from both Old and New Worlds. This evidence comes primarily from early chroniclers as well as the visual arts.[5,7] Indications of syphilis in the New World were first noted by Farquhaison in 1875 in Davenport, Iowa.[8] Williams claimed four skulls as syphilitic, one from Pecos, New Mexico, two from Paracos, Peru, and one from Ohio.[8]

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In 1922 Hrdlička noted the possibility of syphilitic bone lesions in Florida Indians.[9] Brothwell analyzed eight Florida Indian skeletons with possible syphilis from the Hoor's Island site although he questioned their pre-Columbian date.[9] In the same study, Brothwell supported the presence of treponemal disease in a pre-Columbian burial mound in St. Petersburg, Florida.[9] The presence of treponematosis in Florida was also reported by Bullen in a survey of skeletal collections from 14 archaeological sites.[10] An adult female skeleton dated A.D. 850 from Osprey, Florida was diagnosed as syphilitic.[10] Referring to this specimen Hackett stated, that it "...had changes rather like caries sicca," and that, "there is no doubt that an infection was present in these bones of Bullen," but he also added caution in accepting this specimen as proof of the presence of syphilis in Florida before European contact.[11]

A survey of the literature indicates that there are no ancient specimens with a definite diagnosis of venereal syphilis in the New World that would satisfy the criteria of most experts.[5,9,11] If an archaeological specimen has the typical gummatous destruction of bone, which occurs in the late tertiary stage, then a diagnosis can be made rather easily. Otherwise the early stages of tertiary bone lesions are nondiagnostic and confusing since many bone lesions, for example, those of neoplastic disease, are similar in appearance and distribution. The purpose of this paper is to describe two prehistoric specimens which appear to display the early stages of tertiary syphilis which would eventually become gummas.

Materials and methods • The two specimens, Nos. N5-3 and W3-C, were excavated by the senior author from an Indian burial site in the summer of 1980.

The site (8Pb11) was located in the town of Highland Beach, Florida in southern Palm Beach County along the Atlantic Ocean. Approximately 150 skeletons were recovered and analyzed. Based on archaeological evidence of pottery sherds (Glades Plain, Belle Glade Plain, St. Johns Plain, St. Johns Check Stamp) bone needles, and small ornamental objects the site was dated A.D. 600-1200.[12,13] All the remains were secondary burials, which were found in a disarticulated and commingled condition. According to Sears,[14] before burying a deceased individual, prehistoric Indians of South Florida, especially of the Lake Okeechobee region, first macerated the remains and then placed them on a wooden platform. Such a burial practice might have also been carried out by the people of the prehistoric Highland Beach region.

Specimen No. N5-3 was an adult cranium lacking the postcranial bones (Figs. 1-4). This skull was fairly well preserved and was reconstructed by us. The maxilla and associated teeth were incomplete. Of the mandibular dentition, six teeth were in situ, three lost after death, and the remaining lost antemortem. The skull was light tan in color due to the ground water staining and there was moderate mineralization. No. N5-3 was determined to be a male via morphological features including moderate sized supraorbital ridges, a slightly sloped frontal bone, moderately large mastoid processes and a bilateral chin. This individual was determined to be about 30 years old estimated from ectocranial suture closure and moderate dental wear.

No. W3-C was a cranium found without any postcranial skeletal material (Fig. 6). This skull was better preserved. Small portions of the left and right parietal bones were missing. The maxilla and associated teeth were intact with the exception of a chipped right first molar and a missing right second premolar. The mandible was also available less a left third molar. The skull was light tan in color and showed moderate mineralization. No. W3-C was determined to be a male from morphological characteristics including large supraorbital ridges, sloped frontal bone, large mastoid processes and a bilateral chin. This individual was judged to be about 30 years old using ectocranial suture closure and dental wear criteria. Both crania were evaluated by gross inspection comparison with positively diagnosed specimens and radiography.

Pathology • Gross inspection of specimen No. N5-3 revealed the pathologic conditions of severe periodontal disease, a benign tumor of the right mastoid process, infection of the maxillary sinuses at the base of the nose, and lesions of the cranial vault. The cranium contained 12 lesions distributed as follows: eight on the frontal bone, one on the left parietal bone and three on the right parietal bone (Figs. 3-4). All of these abnormalities were only visible on the outer table and did not cross suture lines. There was some pseudopathology consisting of chewing by rodents.

Gross inspection of specimen No. W3-C revealed pathologic conditions of a maxillary abscess at the root of the first molar, a left mandibular abscess around the alveolus of and inferior to the second



Fig. 1. — No. N5-3, frontal view showing ectocranial surface contains 8 lesions ranging from superficial cortical bone loss to circular deep pits with the diploe exposed, and a right mastoid tumor.



Fig. 2. — No. N5-3, cranial base showing narrowing of the sinus and thickening of the walls.

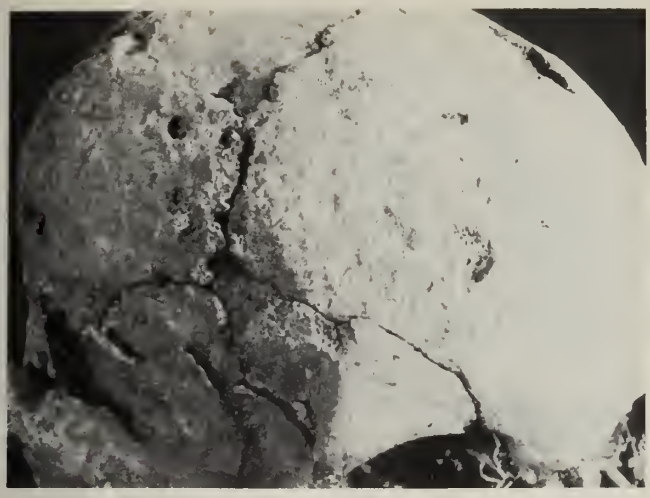


Fig. 3. — No. N5-3, right frontolateral view showing a deep cavity with irregular border and diploe exposed approximately 31 mm above superior aspect of the right orbit.

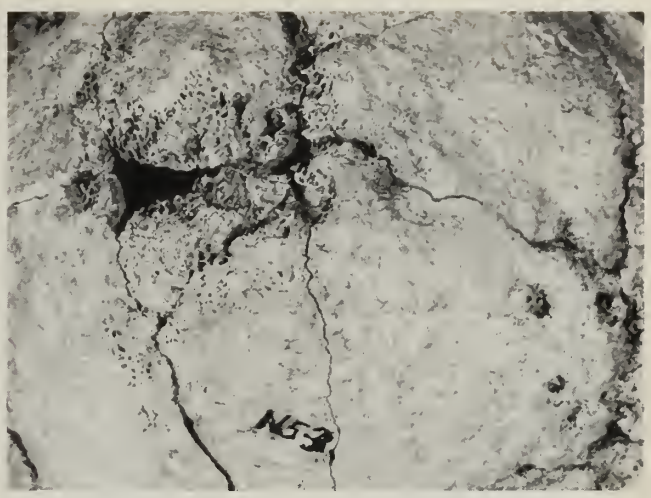


Fig. 4. — No. N5-3, right lateral view showing five lesions posterior to the coronal suture displaying cavitation with the diploe exposed.

premolar and first premolar, and severe erosion on the body and ramus on the left side of the mandible (Fig. 5). The vault also contained several lesions: ten on the frontal bone, five on the left and right parietal bones (Fig.6). All of these abnormalities, as with the first specimen, were only visible on the outer table and did not cross suture lines. This specimen also showed some gnawed erosion from rodent chewing.

Radiographs were taken of both specimens following the technique described by Ortner and Putschar.[15] The radiographs of both individuals displayed erosion of the outer table with some thickening of the cranial vault which is indicative of an inflammatory process.[16] Also, there were neither destructive areas nor sclerotic patches typical of late tertiary lues (Figs. 7-10).

Conclusion • A definite diagnosis of any pathological entity is difficult from dried bone specimens because of incompleteness of the skeleton, lack of soft tissues, environmental factors (soil type, animal vectors), and the difficulties of separating similar lesions. A suspected syphilitic bone must be differentiated from, for example, tuberculosis and neoplastic disease.

The diagnosis of tuberculosis has raised many questions among paleopathologists. Many questionable specimens have been continually reexamined for a more definitive diagnosis. One difficulty is the lack of well-preserved subadult specimens. Also, in the judgment of many experts, such as Steinbock,[1] tuberculosis may not have been present in pre-Columbian hunting and gathering societies in the New World. The early osseous lesions of tuberculosis



Fig. 5. — No. W3-C, left side of the mandible showing an abscess around the alveolar process of the first and second premolars and erosion on the body and ramus.

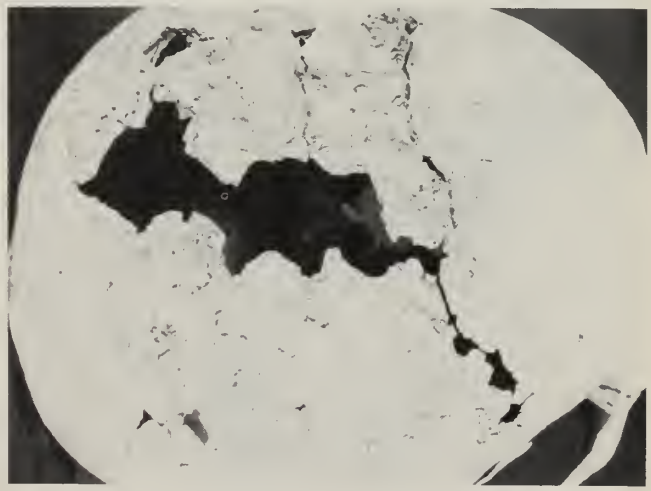


Fig. 6. — No. W3-C, right parietal view showing a moderately roughened surface with a deep cavity approximately 23 mm posterior to the coronal suture.



Fig. 7. — No. N5-3, posteroanterior view showing ectocranial erosion with thickening of the vault.



Fig. 9. — No. W3-C, posteroanterior view showing ectocranial erosion with thickening of the vault.

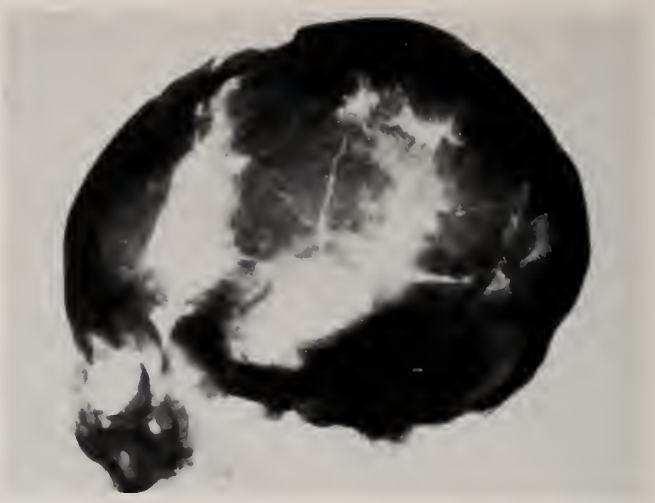


Fig. 8. — No. N5-3, right lateral view showing ectocranial erosion with thickening of the vault.

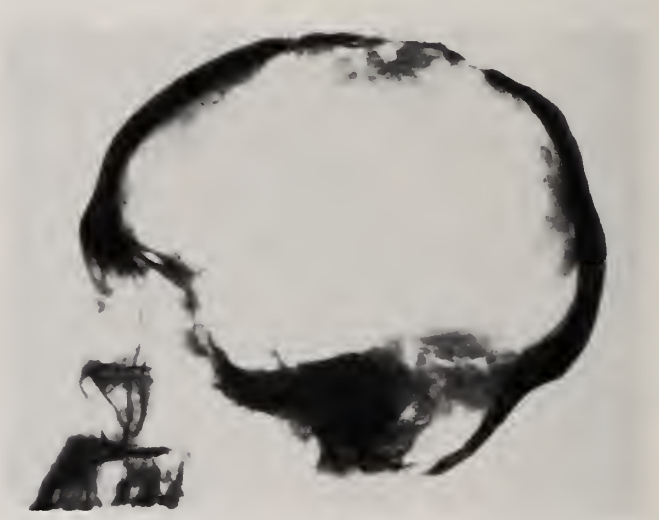


Fig. 10. — No. W3-C, right lateral view showing ectocranial erosion with thickening of the vault.

resemble those of syphilis. Tuberculosis does, however, differ from syphilis in two important ways. First, the lesions affect the inner table before the outer table and, second, the lesions cross suture lines. The Highland Beach specimens Nos. N5-3 and W3-C have no endocranial lesions and the lesions do not cross suture lines. Therefore, the lesions of these two individuals would not be indicative of tuberculosis.

The osseous lesions of neoplastic disease also resemble those of syphilis and, therefore, must be ruled out. Multiple myeloma is a possible diagnosis but the specimens lacked the usual criteria. Multiple myeloma usually affects individuals of an older age group. Its lesions, as pointed out by Hackett,[11] are first evident on the inner table and the lesions cross suture lines. These two specimens have lesions with

only ectocranial involvement and do not cross suture lines so they fail to meet the criteria for a diagnosis of neoplastic disease.

Two other pathologic conditions, Paget's disease and pyogenic osteomyelitis, may be proposed to explain the lesions observed in these specimens. Paget's disease can be excluded because the early lesions (osteoporosis circumscripta) are characterized by marked thinning of the inner and outer tables.[15] Advanced Paget's disease exhibits thickening of the calvarium by endocranial and ectocranial new bone formation with enchroachment on the intracranial space.[15] Pyogenic osteomyelitis, which affects the skull rarely, can also be excluded by the lack of the characteristic sequestra and extension of an empyema of the sinuses into adjacent bones.[1,15] Our specimens did not possess such characteristics.

Specimens N5-3 and W3-C fit within Hackett's[11] model of the caries sicca sequence first described by Virchow in 1858. Although the specimens are not typical because they lack the associated advanced gummatous lesions of tertiary bone syphilis, we feel that by identifying the early lesions of syphilis more information can be added to the status of the origin or origins of treponemal disease in the New World.

Despite the limitations of incomplete skeletons and of having only two cases, we believe that the specimens are suspected syphilis and add to those previously reported in the literature for the New World. This report also provides insight into the difficulites of the paleopathologic diagnosis of syphilis in dried bone specimens.

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NOTES & NEWS

Dr. Goetz appointed Impaired Physicians Medical Director

The appointment of Roger A. Goetz, M.D., as full-time Medical Director of the Florida Medical Association's Impaired Physicians Program was announced by FMA Executive Director Donald C. Jones.

Dr. Goetz, 50, comes to Florida from Columbia, S.C., where he was corporate director of medical affairs for a large corporation which operates addiction treatment programs in Georgia, South Carolina and Illinois.

In the Florida post, Dr. Goetz succeeds Dolores A. Morgan, M.D., of Miami, who had held the position on a part-time and acting basis since 1980. Dr. Morgan did not apply for the permanent position.

"We are most fortunate in being able to attract a professional of Dr. Goetz's caliber and background," Guy T. Selander, M.D., Jacksonville, Chairman of FMA's Committee on Impaired Physicians, observed. "We have made substantial progress over the last 4½ years in our program to identify, treat and rehabilitate physicians with addictive diseases.

"We are very grateful to Dr. Dolores Morgan for agreeing to take on this job in addition to all her other jobs back in 1980. Without her, we would be miles short of where we are today."

Dr. Goetz, Dr. Selander said, will be working to refine and expand the program, which has admitted, treated and in most cases rehabilitated about 200 alcoholic and drug-addicted health professionals including physicians, osteopaths, dentists, pharmacists, veterinarians and others.

He will work with the Florida Board of Medical Examiners, other state professional groups and local impaired physicians commititees. He will form intervention teams, develop educational programs and standards for treatment facility accreditation, and supervise after care and follow up.

Dr. Goetz is a native of Milwaukee, WI, and received his medical degree from Marquette University School of Medicine. He is certified by the American Board of Anesthesiology and is a member of numerous medical organizations, including the American Academy of Addictionology, of which is is a director. He has held teaching appointments at the Marquette and University of Illinois schools of medicine.

In South Carolina, he was chairman of the treatment management team and a member of the Impaired Physicians Committee of the Medical Society of South Carolina. For the past five years he has been active in intervention, detoxification and treatment of impaired physicians.

Dr. Goetz and his wife, Mrs. Kay Orr-Goetz, have appeared on numerous national and local radio and television programs and have been featured in magazine and newspaper articles. They will reside temporarily at Fernandina Beach, and he will maintain his office in Jacksonville.

Seminole County Department of Health and Human Services dedicated

The new Seminole County Department of Health and Human Services was officially dedicated on February 6. This new 30,000 square foot facility, funded totally by the County through a Health Trust Fund established three years ago, houses the County Health Unit, Veterans Services Offices and the County Welfare Office.

The Health Department in Seminole County is a functional facility with a clinical laboratory to support clinical services. It has a new Environmental Health laboratory to test water, food and air for bacteriological contamination and for chemical composition. The new facility also houses a new pharmacy and three dental operatories.

At the opening of the facility, Health and Rehabilitative Services District VII Administrator, Paul Snead and three County Commissioners, Sandra Glenn, Fred Streetman and Chairman Robert Sturm spoke on the history of health services in Seminole County and of the disarray of health services a few years ago which led to a unique partnership between the County and Health and Rehabilitative Services in the provision of a coordinated effort in delivery of health services through better direction, new leadership and a true partnership which in a sense preceded the Chapter 154 Legislation. Jorge Deju, M.D., the Health and Human Services Director, welcomed the attendees and thanked the Health and Rehabilitative

Services, the Health Unit staff, the community service agencies, the hospital and medical community and our volunteers.

This partnership and integration of a leadership role between the County and State has resulted in Seminole County in a betterment of health services, in an increase in such services, in new programs and in a significant reduction in infant mortality and infectious diseases.

Dr. Boyce elected Governor of the American College of Gastroenterology

Dr. H. Worth Boyce Jr., a practicing gastroenterologist in Tampa, was elected as a Governor of the American College of Gastroenterology for the state of Florida at the College's recent Annual Meeting in Toronto, Canada.

The American College of Gastroenterology is a professional association of practicing clinical gastroenterologists, physicians who diagnose and treat diseases of the digestive system. The American College of Gastroenterology exists to provide its over 1,800 members with continuing medical education in the treatment of patients with digestive disease problems, as well as publishing information on digestive diseases through its affiliation with various entities, such as the National Digestive Disease Education Program.

As a Governor, Dr. Boyce represents College members in Florida on the Board of Governors, an administrative body of the College composed of Governors throughout the United States, Canada, and other countries.

USF's gerontology center initiates seminar

The International Exchange Center on Gerontology at the University of South Florida is cosponsoring a seminar entitled "Returning from the Sunbelt: Myths and Realities of Migratory Patterns Among the Elderly" on March 15 at Columbia University.

Initiated by the gerontology center and cosponsored with the Brookdale Institute on Aging and Adult Human Development at Columbia, the program will focus on a recent report conducted by Dr. Charles P. Longino Jr. about the reverse trend in the migratory patterns of the elderly. Longino, Director of the Center for Social Research in Aging at the University of Miami and a member of International Exchange Center on Gerontology advisory board, will present his research and lead discussion about the economic, housing, environmental, service and family support implications of his findings.

Dr. Harold Sheppard, Director of the International Exchange Center on Gerontology at USF, will be a featured speaker at the seminar. Attendance for this program is limited to 40 registrants. For more information, please contact Sheppard at (904) 974-3468.

"Alliance for Care" conference to be held

"Alliance for Care", a conference unique in its approach to planning and assessing community-based services for frail elderly, will be held March 5-8, 1985 at the Hyatt Regency in Miami. Co-sponsored by the Miami Jewish Home and Hospital for the Aged and the Area Agency on Aging of Dade and Monroe Counties, the conference is unprecedented in bringing together national and international leaders in human services, health care, gerontology and government, advocates and consumers. For further information contact Ms. Randi Freedman at the Miami Jewish Home and Hospital for the Aged, 151 Northeast 52nd Street, Miami, 33137, (305) 751-8626. FMA is an "agency endorser" of this program.

Dr. Saltz elected to fellowship in ACP

Richard K. Saltz, M.D., Boca Raton, has been elected to Fellowship in the American College of Physicians. Sixteen thousand physicians have been so honored in the 60,000-member national medical specialty society. Dr. Saltz, a gastroenterologist, is one of 300 who have been elected this year. Election to Fellowship in the College signifies that a physician has been recognized by his colleagues as having attained a level of medical scholarship and achievement in internal medicine.

Dr. Saltz graduated from the Georgetown University School of Medicine in 1978. He is currently on the staff of Holy Cross Hospital, North Ridge General Hospital, Humana Hospital Cypress, and North Beach Community Hospital.

Dr. Brown honored by the Medical Association of the Bahamas

William T. Brown, M.D. was honored by the Medical Association of the Bahamas at their Annual Medical Conference on January 19, 1985. A plaque was presented to him by Sir Gerald Cash, Governor General of the Bahamas on the behalf of the Medical Association and Percival McNeil, M.D., President of the Medical Association, for twenty-three years of service to the people of the Bahamas.

Dr. Earle Farrington, Fellow of the Royal College of Surgeons and Chief of the Department of Surgery at the Princess Margaret Hospital in Nassau, gave the oration on behalf of Dr. Brown.

DEAN'S MESSAGE

The humanities in medical education

There is great concern from both outside as well as from within the medical profession and from educators and practicing physicians, with regard to the educational process leading to the M.D. degree. The recent report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine is symptomatic of this continuing concern. The prevailing view is that undergraduate curricular choices are driven by such fierce competition for a maximum grade point average in the sciences that no room remains for the humanities. The medical school curriculum in turn leaves little room for maintenance let alone enhancement of an interest in the humanities. The result is the graduation of scientifically sound but culturally bereft doctors.

The goal seems to be to include a classical education, meaning in this case an education in the classics in the background of the physician. This should result in a more articulate physician and, it is hoped, a more humanistic one. However, this is not in the near term a very realistic or achievable goal. Its implementation depends on the undergraduate education system. Medical students represent only a small fraction of the undergraduate output. A change in the curricular choices by premedical students is another unrealistic expectation. It seems unlikely that a reduction in the courses required for admission to medical school (ten or twelve credits at most) will occasion any greater drift towards the humanities than the 120 credit hours now required to graduate. Short of requiring a minor in humanities for admission to medical school, it seems likely that the best cause will be to support long term revision in order to emphasize humanities as an essential component of college preparation of medicine. The results are likely to emerge from the pipeline with a substantial, probably eight year, delay.

In the meantime, there are steps that can be taken to foster education in humanities after the student is admitted to medical school. Not all students arrive in medical school as scientific idiot savants. Many do bring a devotion to one or more of the humanities. They need an extracurricular opportunity within the school to foster and maintain their interest in art, drama, history, music and literature. For those students without an established background in any of the humanities, any attempt within the medical curriculum to make up the missed undergraduate opportunity would be ill timed and probably futile, but the time is right to offer generous helpings of medical humanities, the history of medicine, medical artists and medical art, physicians as authors and poets, and human values in medical practice. This is, after all, the stuff of which our profession is made. Without question, it deserves a place in the curriculum. If the goal is to produce a physician educated in scientific medicine and perceptive of human values as well, then we can do no less.

Unspoken, as far as I am aware, is a role for medical humanities in the continuing education of the graduate physician for whom growth in the perception of human values is as essential as remaining abreast of developments in scientific medicine.

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Physicians for the Twenty-First Century: The GPEP Report. Report of the Panel on the General Professional Education of the Physician and College Preparation for Medicine. Association of American Medical Colleges, Washington, D.C., 1984.

William A. Sodeman Jr., M.D.
Deputy Dean for Academic Affairs
University of South Florida
College of Medicine, Tampa

WORTH REPEATING

Medical care in a changing economic environment

Change seems to be a constant in medical care. The frequent revisions of standard textbooks attest to the speed at which new knowledge about physiological processes, diagnostic techniques, and treatment is accumulating. Practitioners flock to programs in continuing medical education in an attempt to keep up with the state of the art. Yet, human physiology remains the same; the rapidity of change derives from our increasing knowledge about physiology and how better to diagnose and treat medical problems. The situation is actually more complex if one views the medical care system as a patient. Not only are health services researchers only beginning to understand how our system works, but the system itself is constantly changing.

To place things in perspective, I shall first briefly review the changes that have taken place in the last four decades, a period about equal to the time between medical school graduation and retirement. Then I shall present a stylized picture of the

good old days — an era that I suggest is drawing to a close. Then I shall outline my expectations concerning changes likely to occur in the short, intermediate, and long run. Finally, I shall explore some of the implications of these changes.

Looking backward • One way to visualize the changes that have taken place is to consider them from the perspective of a physician now approaching retirement at age sixty-five. When World War II was just coming to a close, a newly graduated physician faced a promising medical environment and an uncertain economic future. Antibiotics were just becoming available, and new surgical techniques had been developed during the war. The Great Depression was still a vivid childhood memory, however, in which physicians were often presented with patients who had no way of paying for their treatment. Demobilization meant that thousands of experienced physicians were leaving the military to return home and begin competing with young graduates for patients. Specialty training was an option that required careful consideration — only a small fraction of new physicians in the 1940s went into specialty practice.[1]

Even in the 1940s the medical care environment was beginning to change. Voluntary health insurance coverage for physician and hospital services was introduced during the Depression in some areas. While initially opposed by the American Medical Association, Blue Cross and Blue Shield plans grew and offered the promise that patient's bills would be paid, especially for expensive inpatient care. More ominous, however, were proposals by President Truman for some form of national health insurance. Physicians' memories of medical care regimentation while in the military, coupled with a massive lobbying effort by the AMA in 1948, killed all prospects for a national program for at least a decade.[2]

The 1950s was a relatively quiet and prosperous period for the medical care system. The Hill-Burton program channeled federal money into hospital construction. Major new drugs, including polio vaccine in the mid-1950s, became available and enhanced the profession's image and the public hope that cures to other major killing and crippling diseases would soon be found. The wide availability of antibiotics precipitated a sharp reduction in deaths due to pneumonia and infectious disease.[3] Federal tax laws dating back to the mid-1940s exempted employer contributions for health insurance; so it became a popular fringe benefit, and the proportion of the population with coverage grew from 25 percent in 1945 to 69 percent in 1960.[4] Commercial life and disability insurance companies expanded their share of the health insurance market, especially among employee groups, by offering experience-rated policies with low premiums to companies with young, healthy enrollees. The Blue Cross and Blue Shield plans typically offered community-related policies, open to all, and thus ended up with an increasing proportion of the elderly. By the mid-1950s, the Blues began to experience-rate in order to compete.[5]

In the 1960s a Democratic administration and Congress reintroduced the idea of federal funding for medical care. As before, it met stiff opposition from the medical establishment amid fears of a bureaucratic takeover. This time, however, the Blue Cross and Blue Shield plans were eager for federal assumption of responsibility for the elderly, and hospitals were ready for a program to reduce their mounting bad-debt problem. The passage of Medicare and Medicaid in 1965 was perceived by some physicians as heralding the end of "private practice." In the short run, they were wrong; it was the beginning of a Golden Age. In the long run, changes were set in motion that continue to influence the structure of the medical care environment. Both Medicare and Medicaid paid physicians on a fee-for-service basis, often using established third-party insurers, such as Blue Cross, as intermediaries. Hospitals initially were paid on a cost-plus basis. The purpose of the federal legislation was to improve access to medical care for the elderly and the poor, and in this respect the programs were successful. Utilization of services by the targeted groups increased substantially, although some remained underserved.[6] With the expansion of coverage, there was serious concern that demand would outstrip supply, and, to deal with the perceived doctor shortage, medical schools were subsidized to expand enrollment.

During the decade of the 1970s rising medical care expenditures became an increasing topic of discussion and concern in policy circles. Professional Standards Review Organizations (PSROs) were established with the dual purpose of assuring high quality care for hospitalized Medicare and Medicaid patients as well as reviewing cases to reduce unnecessary treatment and hospitalization. States found their portion of Medicaid expenditures growing much more rapidly than could be supported within their budgets, so physician fees were frozen or cut, eligibility was tightened, and benefits were reduced. Hospital and medical school expansion continued, but with decreasing reliance on direct subsidy and increasing reliance on revenues generated through patient care and borrowing. Health planning agencies attempted to reduce costs by restricting hospital expansion, especially for specific services — such as open-heart surgery and computerized axial tomography units. Physicians responded to new restrictions in a variety of ways, including some attempts to "work the system" by billing for services with higher reimbursement levels than those actually

rendered. Many stopped accepting new Medicaid patients, claiming that reimbursement did not cover the cost of care.

In the early 1980s further changes were made in an effort to constrain medical care expenditures, which reached levels exceeding 10 percent of the Gross National Product in 1982.[7] The Omnibus Reconciliation Act of 1981 allowed Medicaid programs to restrict freedom of choice, limiting beneficiaries to selected hospitals and provider systems. The 1982 Tax Equity and Fiscal Responsibility Act instituted target payments to hospitals for Medicare patients. An especially controversial Medicare regulation, instituting prospective payment for hospitals based on Diagnosis-Related Groups (DRGs), was introduced in 1983.

The medical care system today • A stylized view of the medical care system in the early 1980s will provide a basis for comparisons with projections of the future. While this stylized picture omits certain exceptions and details, it is designed to represent the key features of the current system. Most consumers are enrolled in some form of health insurance plan through their place of employment. Most employers offer a single plan and pay a substantial portion of the premium. The typical plan requires some copayments by the patient, but these are typically fairly small. Hospital coverage is more comprehensive than that offered for ambulatory care. Professional fees are typically paid up to a usual, customary, and reasonable (UCR) scale. Medicare for the elderly and Medicaid follow similar patterns but with somewhat lower fee levels. While there are sometimes constraints on fee levels or allowable hospital charges, and perhaps some utilization review by the insurance carrier, there is little constraint on the number and mix of services rendered to the patient. From the perspective of the provider — either the hospital or physician — it is appropriately called a reimbursement system. That is, the more one does, the more one gets paid, in spite of the fact that the rate of payment may vary. Thus, if a laboratory test might provide some data — do it; if a treatment might help — offer it. With this philosophy the implicit rule of thumb is — if the clinical benefits seem to outweigh the side effects — do it, because cost to the patient with insurance is minimal and cost to society is irrelevant.

In addition to this general environment, which encourages more, rather than less, there are built-in biases in the payment system that artifically affect specialization patterns. For a variety of reasons, some types of medical interventions — especially those involving surgical procedures and new technololgy — yield higher fees per hour than one-on-one patient contact does. Thus income levels vary substantially among specialists. Even the American Medical Association has authorized a study of the implications of unequal payment for different types of medical interventions.[8]

Looking ahead • Recent changes in Medicare payment to hospitals indicate an end to the era of reimbursement and the beginning of a prospective payment system predicated on DRGs. Hospitals will receive a fixed number of dollars for each patient admitted with a specific diagnosis. This reimbursement may be more or less than it costs that particular hospital to provide indicated care — if more, the money is available for other purposes, if less, the difference must be made up in other ways. Clearly, a new set of incentives will emerge. In the short run, providers may manipulate medical records to reduce losses, but in the long run they may be strongly induced to become more efficient treatment providers.[9] A source of imbalance in the system is that physicians are still paid on a fee-for-service basis, bringing them into conflict with the hospitals. Whereas new residents have in the past been encouraged to do comprehensive workups on every patient, they may in the future get mixed messages from hospital directors and attending physicians, with the former asking for reduced use of laboratory tests.

The health care system will continue to change in reaction to the pressures exerted by the policies already in effect. Some of the changes will likely occur in the very near future; others are intermediate run changes within the next three to five years; and yet others are likely to occur in the long run, or in about ten years.

In the short run, DRG payments to hospitals will be modified and tightened as problems with the system are identified. The notion of payment per case — probably on a DRG basis — will gradually be adopted by other, non-Medicare payors. The conflicts between hospitals and physicians will increase as hospitals attempt to reduce costs, largely through staff cuts and attempts to reduce the use of ancillary services. Physician fees for Medicare and Medicaid may also be frozen. Physicians will probably react by shifting more patients to outpatient settings, which are the last bastion of unregulated service delivery and reimbursement. This move will further reduce hospital occupancy levels and accelerate pressures for cost reduction in the inpatient setting. Some economies of scale may be achieved if high volumes of patients are concentrated in certain institutions.

In the intermediate run, physician fees for inpatient care will be incorporated within DRGs, making incentives for physicians and hospitals more consistent. If physicians develop ways of treating patients less expensively, they can share the savings with the hospital, opening a new arena for creative thinking and negotiation as physicians and hospitals decide

how to split a given amount of reimbursement. Services and facilities are likely to become more regionalized, especially for the most expensive services. Hospitals that can develop high-volume programs will achieve economies of scale and better outcomes, thus wooing physicians, while hospitals with low volumes will have to close units. Requests by physicians for new equipment and services will be viewed by the hospitals as potential joint ventures, reducing duplication and encouraging the arrangement of consortia among hospitals and physicians.

As insurers attempt to identify cost-effective providers, they will look beyond the cost per unit of service, such as the charge for an office visit, to cost per episode of care. Insurers will develop practice profiles for primary care physicians to identify those who care for their patients at relatively low total cost. Incentives will be offered to reward low-cost physicians and hospitals by channeling more patients to them. Currently established Preferred Provider Organizations will undergo further changes and increase their sophistication in developing practice profiles, referral systems, and utilization controls.[10]

In the longer run, there will be continued integration of delivery systems, with more focus on cost per enrollee per year, as in Health Maintenance Organizations (HMOs) at the present time. More attention will be paid to practice styles to determine the most efficient patterns. The trends to develop "humane care systems," such as hospice, will continue to reduce the expense of care in the last year of life. There will be substantial patient involvement in personal health care, with increased focus on nonmedical interventions and less emphasis on technology. Patients will have more options to self-select supportive treatments. The present holistic health movement, with its emphasis on wellness and prevention, will continue, with more encouragement from medical practitioners, if only because it can attract people inclined to use less expensive forms of treatment. Health promotion through public education and personal incentives will become the norm, with technology developing to encourage and enforce desired behavior. Examples are lower insurance rates for drivers who install "drunk-driving locks" on autos and lower rates for nonsmokers.

An important result of these changes will be a markedly reduced demand for medical care resources. Hospitals will close or be converted to other uses, such as nursing homes. Physicians will find themselves in less demand at the same time that supply is increasing rapidly. Some will leave the profession; others will be satisfied with lower incomes and more leisure.

Implications • If even half these changes come to pass, the practice of medicine will have changed substantially, but, as I indicated earlier, the changes in the last forty years have already been immense. If we look to the future, rather than the past, we may see in the upcoming changes equally exciting challenges.

The era of rapidly rising incomes for all physicians is over. Some physicians will be able to succeed, but others will not. Physicians will need to consider lower-cost treatment options, and they will receive greater rewards for creative thinking than for using technology. Specialists may become very efficient, but their patient flow will be controlled by others, and many specialists will find their skills unneeded. Primary care physicians will have a wider range of options and a greater ability to control their environment, but they, too, will find it difficult to retain their customary independence. While the future will definitely differ from the past, it will present both advantages and disadvantages for patients, physicians, and society. Furthermore, the changes currently in progress are pressures to move in certain directions, but the specifics are not preordained. Unlike naturual processes, the social system is malleable, and creative approaches have a good chance of succeeding in an era of rapid change.

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Harold S. Luft, M.D.
San Francisco, CA

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CORRESPONDENCE

Dear Editor: Recently when I was in Honolulu for the House of Delegates meeting in early December, I had the privilege of sitting in on the early meetings

of the Florida Delegation. It has been 40 years since my graduation from the University of Michigan Medical School, and the majority of those years I have been a member of the American Medical Association. For the past twenty two years I have been a member of the Florida Medical Association. I believe that I represent the average American doctor who has basically felt that being a member of the county, state or national medical associations was something beyond that which he had been called to do as a physician. I have heard it said that good doctors are involved in the care of their patients and they do not have time to be involved in medical politics. It may very well be that I have made that statement myself.

Not long ago, I read that people deserve the kind of government which they have. This had to do with national governments. However, the same thing is true of Medicine. It might be said that the kinds of changes which have occurred in Medicine during the past forty years have been a result of that which we have brought upon ourselves.

Thus it came as a rather resounding shock to me to find that there was such a high degree of dedication and obvious ardent work and endeavor displayed by the doctors who represent Florida at the House of Delegates meetings. As I looked at Frank Coleman and realized that he had spent an untold number of hours and a tremendous amount of work in trying to get something done about the malpractice problem that we doctors in Florida are facing, I realized that at that 6 a.m. meeting he was there involved in every aspect of those activities that have to do with every Florida physician. In looking at him, I realized what a toll his endeavors for us had taken upon him in fatigue and in what could be called the "catabolism" of effort over and beyond all self consideration. Frank and the other physicians and their aides were present, were there early every morning for the Florida Caucus meetings and beyond that, were involved in numerous other meetings and activities, including the general meetings in which the various resolutions brought before the Congress were either accepted or rejected.

On the final morning of our Florida Caucus meetings I made mention of the fact that I appreciated that the Florida Delegation had been supportive of our national endeavor to try to get the Religion and Medicine Committee reestablished in the AMA. This resolution was presented to the meeting by the State of Georgia delegation. Beyond this, I stated that I felt that the doctors of Florida should be aware of the tremendous amount of effort and work and dedication which I saw demonstrated there in Honolulu. I apologized for the fact that I had not understood the degree of effort and dedication which these men and women had so obviously demonstrated in the Honolulu meetings. This is not only true, I said, of the Florida Delegation, but of every other delegation which I had the privilege of meeting and speaking with.

In response to my remarks, Bob Windom suggested that I write this letter to the Editor of the Journal of the Florida Medical Association. Thus the letter is written. It is submitted with heartfelt thanks for my friends, the Florida Delegation and the FMA and AMA in general. It is my belief (and this comes from a grass roots doctor of forty years standing) that it is about time that all American physicians get behind the AMA 100% and stop taking potshots at our organization - which are usually made in ignorance or in prejudice by people like myself who have never really bothered to see what the American Medical Association is really all about.

The AMA in its national endeavors needs the support of every American doctor, and I believe the time has come for us to begin to support it. Regarding our efforts to get the Religion and Medicine Committee reestablished in the AMA, our resolution was not defeated, but was referred back to the Board of Trustees. It is our hope that at the upcoming meeting in June of 1985, this resolution will be passed.

Thank you Frank, and Bob Windom and Charles Donegan and Vern Astler, and all of you members of the Florida Delegation, for representing me and the Florida doctors, who like me in times past have never taken the time to say "Thank you and God bless you."

William S. Reed, M.D.
Tampa



SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"Grandpa scam"

The so called "grandpa scam" involves what appears to be an innocent young girl and her supposedly terminally ill ("stomach cancer") grandfather, who are enroute from Alabama (or some other place) to Oregon (or some other place) so that grandpa can be with kinfolks when he "passes".

The old man willingly shows his scarred abdomen and explains that he had surgery at a V.A. (or other public) hospital. He further explains that he is

in excruciating pain and that he is allergic to certain pain remedies. The conversation usually comes around to DILAUDID or DEMEROL - which the old man agrees has been used before with good results.

After obtaining the prescription, usually an inordinately large amount ("he's a long way from Oregon"), the couple sells the drugs to local street dealers, usually for $15 to $20 per unit dose. The pair are reported to frequently net as much as $5,000 per week. They normally will remain in one community for two weeks.

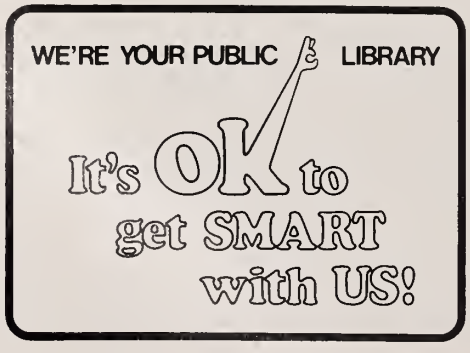
A frequent postcript to this "scam" is where the innocent young girl returns to the physician's office and in an emotional apologetic state reports that "grandpa" has lost his prescription. She is properly appreciative when the understanding physician provides a replacement.

Caution • Physicians are cautioned to be alert to patients who: are unknown to them, demonstrate behavior associated with drug abuse, who have insufficient identification or who otherwise behave suspiciously. A request for positive identification and/or a telephone call or two can be an effective deterent.

CORRECTIONS

"Hepatitis B: another look at prevaccination screening"

The last paragraph on page 935 of the December issue, Vol. 71, No. 22, should have read: "In general medical practice abnormal screening tests must be evaluated, thus, patients may incur costs beyond the original screening costs. For example, it is recommended that household contacts of those with acute infection need to be given HBIG (hepatitis B immune globulin), the acutely infected patient be followed to determine the outcome of the infection, and that chronic carriers, susceptible to many of the complications of chronic hepatitis, be followed regularly[7]."



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Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

A time for the doctor

Today I spoke with a former colleague, a professor of education who asked, "Do you think I should have liability insurancc? There is much talk, these days, about the possibility of students suing professors over grades, performance, and almost anything. The American Association of University Professors is offering a policy for faculty members costing fifty dollars a year." "Fifty dollars!" I exclaimed in amazement as I recalled when liability insurance for physicians was more reasonable. Today the medical profession is painfully aware that liability costs are escalating to new heights. It is a trying time for doctors, their families, and the public.

Although I could offer my friend empathy, I could not deny that fifty dollars may be only the first year's cost. With liability expenses completely changing the pattern of life in our society and the way physicians practice medicine, everyone is affected. Liability consciousness is permeating all segments of the economy.

As we pause to observe Doctors' Day on March 30 these sober thoughts may cause us to weep, mourn, and speak out; however let us not forget to take time for other things. Let us take time to laugh, dance, love, and make peace with ourselves and others. On this day dedicated to physicians, let us reflect on the joys of the profession, the tremendous progress of medicine, and the exciting challenges of the future.

There have been great medical discoveries in alleviating pain and suffering, preventing illness, promoting health, and extending the life span. One of the greatest American medical discoveries was the first use of ether as an anesthetic for a surgical operation by Crawford W. Long, M.D., of Georgia, March 30, 1842. As a result of this achievement mankind was provided with the blessed relief from pain.

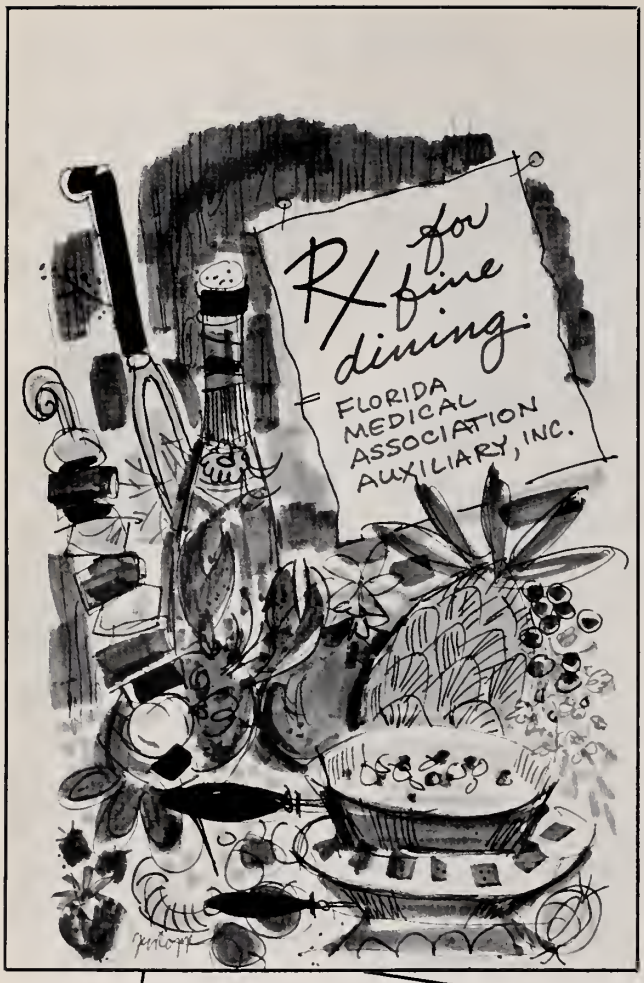
In commemoration of this historic event, the Southern Medical Association Auxiliary initiated the annual observance of Doctors' Day in honor of all medical doctors. Each year on March 30th Florida Auxilians take time to join with others thoughout the sixteen Southern states and the District of Columbia to recognize the significant and unselfish contributions of all medical doctors to the health and welfare of our nation. The spicy scent of the red carnation denoting honorary distinction has become the symbol of this day.

Last year for Doctors' Day the Dade County Medical Auxiliary sponsored a gala celebration of "Symphony, Champagne, and Castanets" in honor of their physicians. A grand total to the tune of $23,000.00 was raised to benefit child abuse prevention projects. For this truly great humanitarian effort, the Auxiliary was awarded the Feldner Trophy at the annual meeting of the Southern Medical Association, as the most outstanding Doctors' Day observance in the South.

This year the Blood Donor Drive on Doctors' Day is extending to a number of counties throughout the South bringing the gift of life to our citizens. The goal of 1,300 pints in one day is the challenge of the Pinellas County Auxiliary. Donors are rewarded with a T-shirt announcing "I Shared a Pint With My Doctor." Other auxiliaries are establishing scholarships for medical students and allied health career students, donating books to libraries, organizing organ donor drives, sponsoring symposiums and workshops on health related topics, conducting health fairs, planting trees and landscaping hospital and nursing home grounds, donating auto restraints for infants.....all in honor of physicians.

Let us take time for the doctor this March 30, Doctors' Day; let us take time to say, "Thank you, Doctor."

Isabella Laude
Babson Park



KEY LIME PIE

"This tried and true recipe is best with a graham cracker crust. It's easy and can be done ahead!"

4 egg yolks, well beaten
1 can sweetened condensed milk
½ cup lime juice (4-6 limes)
*6 egg whites**
½ tsp. cream of tartar
¾ cup sugar
1 9" graham cracker pie shell, baked

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice; mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving.

*You can make the meringue with only 4 egg whites from the eggs you've used

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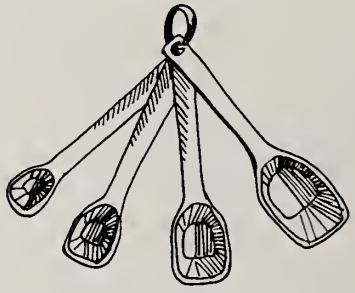
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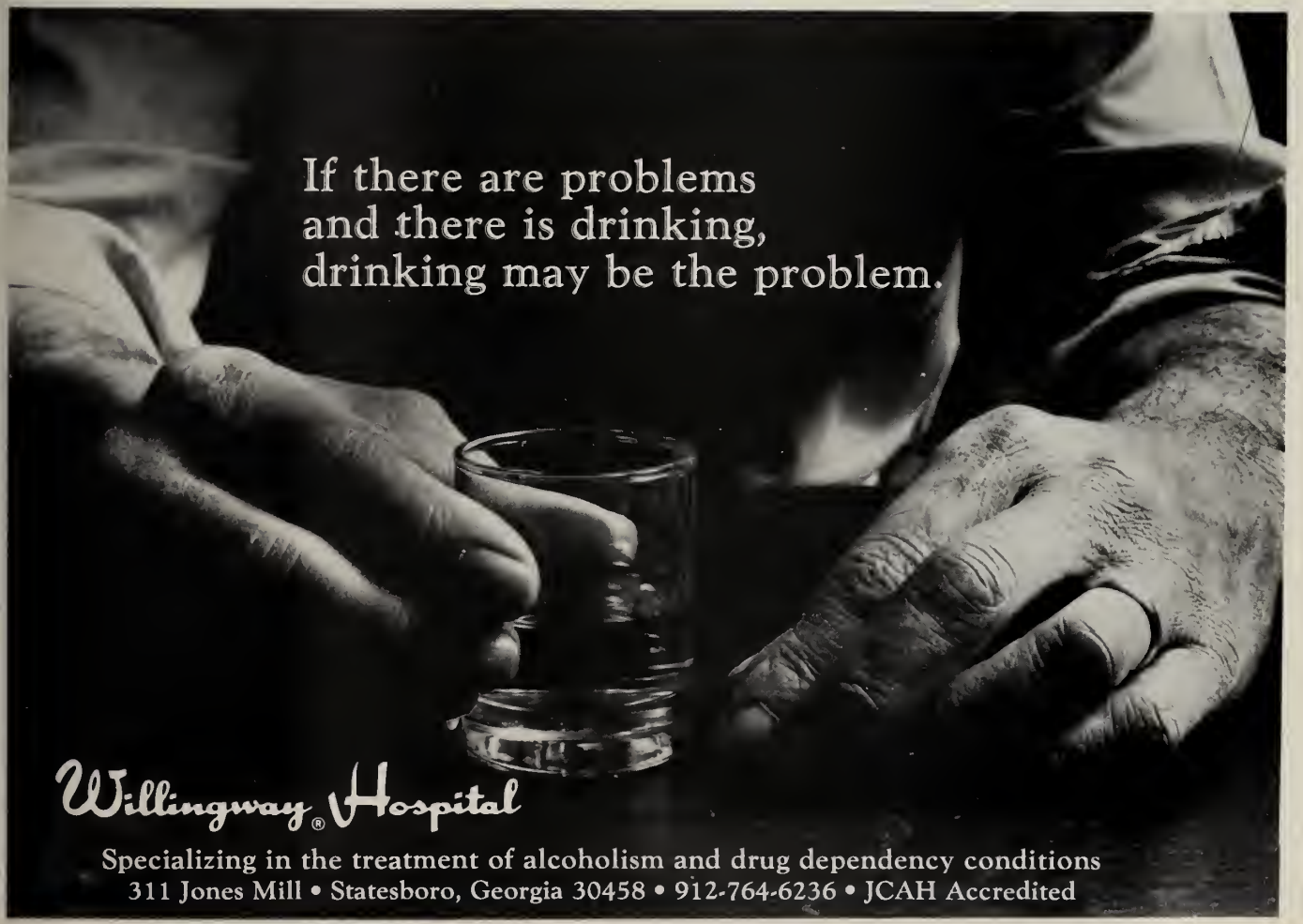
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The Cancer Conference, Mar. 1-2, Hilton Hotel, Daytona Beach. For information: H. Kerman, M.D., 570 Memorial Circle, Ormond Beach, (904) 672-1852.

Perplexing Questions for Pulmonary Medicine, March 2, Rusty Pelican, Tampa. For info.: David Solomon, M.D., 13000 N. 30th Street, Tampa 33612, (813) 972-2000, Ext. 152.

Internal Medicine 1985, Mar. 3-8, Sheraton Bal Harbour. For information: Jose Bocles, M.D., Dept. of Medicine R-760, P.O. Box 016760, Miami 33101, (305) 547-6063.

Medical Seminar at Sea,, March 3-11, Caribbean Cruise. For information: Charles E. Osborne, Ed.D., P.O. Box 3926, Springfield, IL 62078, (217) 782-7711.

Monitoring Geriatric Medicine, Mar. 4-6, The Good Samaritan Hospital, W. Palm Beach. For info.: Daniel N. Tucker, M.D., P.O. Box 3166, W.Palm Bch. 33402-3166, (305) 655-5511 Ext. 4236.

Mediclinics Postgraduate Medical Refresher Course, Mar. 4-15, Holy Cross Hospital, Ft. Lauderdale. For information: Donald Lannin, M.D., 2917 S. Ocean Blvd., Suite 905, Highland Beach 33431, (305) 272-8973.

Intensive Care for Neurological Trauma and Disease 1985, March 6-10, Sheraton Bal Harbour. For info.: Division of CME D23-3, University of Miami, P.O. Box 016960, Miami 33101, (305) 547-6716.

Practical Gynecologic Pathology for the Clinician, Mar. 7-9, Sonesta Bch. Hotel, Key Biscayne. For information: Patience A. Schenck, 600 Maryland Avenue SW, Washington, DC 20024, (202) 638-5577.

Magnetic Resonance Imaging in Medical Practice, Mar. 10-14, Sheraton Bal Harbour. For info.: Manuel Viamonte Jr., M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2680.

Problems in Rheumatology, Mar. 13-16, Don Cesar Hotel, St. Petersburg Bch. For info.: Bernard Germain, M.D., University of South Florida, Box 19, Tampa 33612, (813) 874-2681.

3rd Annual Clinical Management of the Elderly Patient for the Practicing Physician, Mar. 14-16, Americana Dutch Inn, Orlando. For information: Gregor Pawlson, M.D., 7201 Rossville Blvd., Baltimore, MD 21237, (202) 676-4269.

Sarasota National Conference on Pediatric Lung Disease, Mar. 15-17, Sarasota Hyatt House. For information: Gerd Cropp, M.D., 219 Bryant Street, Buffalo, NY 14222, (716) 878-7630.

Basic Coronary Life Support for Physicians, March 18, Sept. 16, University Community Hospital, Tampa. For info: John R. Warren, M.D., 3500 E. Fletcher Ave., Tampa, Fl 33612, (813) 977-3307.

Surgical Update - 1985 - With Duke University, Mar. 18-20, Good Samaritan Hosptial, W. Palm Bch. For information: Barbara Breznen, P.O. Box 3166, West Palm Bch. 33402, (305) 655-5511.

Update in Clinical Nutrition, March 21, University of South Florida, Tampa. For info.: Jay Mamel, M.D., 12901 N. 30th Street, Tampa 33612, (813) 974-2034.

16th Annual Topics in Internal Medicine, Mar. 21-23, University Centre Hotel, Gainesville. For info.: A. Jay Block, M.D., JHMHC J-233, Gainesville 32610, (904) 392-2666.

Vascular and Pulmonary Disease: Diagnosis and Management, March 22-24, Bahia Mar Hotel, Ft. Lauderdale. For info.: Stephen Mattingly, 5808 S. Rapp Street, Littleton, CO 80120, (303) 798-9682.

Meeting of the International College of Surgeons, Mar. 25-28, Buena Vista Palace, Lake Buena Vista. For info.: International College of Surgeons, 1516 North Lake Shore Drive, Chicago, IL 60610, (312) 642-3555.

4th Annual Symposium on Clinical Management of Diabetes and Endocrine Disorders, March 27-30, Don CeSar Resort Hotel, St. Petersburg. For information: Robert Farese, M.D., JA Haley Veterans Hospital, Bruce B. Downs Blvd., Tampa 33612, (813) 972-2000 Ext. 568.

Interesting Topics in Orthopedics, Mar. 28-30, Royce Hotel, West Palm Beach. For information: Michael Zeide, M.D., 7820 Edgewater Drive, West Palm Beach 33406, (305) 433-0797.

The Diagnosis and Management of the Acute MII, Mar. 29-31, Don CeSar Hotel, St. Petersburg. For info.: Beverly Jacobsen, 64 Inverness Drive East, Englewood, CO 80112, (800) 525-8651.

Current Concepts in Prosthetic Replacement of the Hip and Knee, Mar. 31 - Apr. 3, Sheraton Bal Harbour. For info.: Charles Weiss, M.D., 4300 Alton Road, Miami Beach 33140, (305) 674-2121.

Practical Aspects of Newer Cardiovascular and Renal Therapies, Mar. 31-Apr. 3, Hyatt Regency, Orlando. For information: Univ. of Miami, Div. of CME, P.O. Box 016960, Miami 33101, (305) 547-6716.

American College of Surgeons Spring Meeting, Mar. 31-Apr. 4, Miami. For info.: American College of Surgeons, 55 East Erie Street, Chicago, IL (312) 664-4050.

APRIL

Spring 1985 Family Practice Review, April 1-5, Sheraton World Center, Orlando. For info.: William Stewart, M.D., JHMHC J-233, Gainesville 32610, (904) 392-3143.

Interventional Radiology, 3rd Annual Seminar, Apr. 2-6, Walt Disney World Village Hotel Plaza, Lake Buena Vista. For info.: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

Trends and Techniques, Apr. 10-12, Hilton Hotel, Lake Buena Vista. For information: Eileen Coulombe, JHMHC J-294, Gainesville 32610, (904) 392-2893.

Issues and Advances in Pediatrics — 1985, Apr. 10-12, Sheraton Sand Key Resort, Clearwater Bch. For information: Lewis Barness, M.D., 12901 N. 30th St., Tampa 33612, (813) 974-4214.

Cardiology Workshop, Apr. 12, Hyatt Regency Hotel, Tampa. For info.: Joseph E. Holland, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (914) 398-5667.

Family Practice Weekend — Tampa, Apr. 12-14, Hyatt Regency, Tampa. For info.: Joseph Holland, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (904) 398-5667.

Advanced Cardiac Life Support, Apr. 13-14, Pasco-Hernando Comm. College, New Port Richey. For information: James Marlowe, M.D., P.O. Box 1058, New Port Richey 34291-1058, (813) 842-9574.

Sudden Death - Clinical and Pathological Correlation, Apr. 18-20, Bonaventure Intercontinental Hotel and Spa, Ft. Lauderdale. For information: Esther Cohen, 4300 Alton Rd., Miami Beach 33140, (305) 674-2121.

15th Annual Radiation Therapy Clinical Research Seminar, Apr. 18-20, Gainesville For info.: Hal Jacobson, M.D., JHMHC J-385, Gainesville 32610, (904) 392-3161.

The Current Status of Tissue & Mechanical Heart Valve Replacement, Apr. 27, St. Joseph's Hospital, Tampa. For info.: Dennis Pupello, M.D., 3001 W. Buffalo Ave., Tampa 33677, (813) 870-4130.

MAY

Current Concepts in Pain Management, May 10-29, Mississippi Steamboat Cruise. For information: Dr. Berman, 3301 Johnson St., Hollywood 33021, (305) 989-6650.

Master Approach to Cardiovascular Problems, May 25-27, Contemporary Hotel, Orlando. For information: Yolanda Barcena, Dept. of Medicine, Univ. of Miami, Miami 33101, (305) 549-7124.

JUNE

American & European Views on Critical Care, June 8-15, Cannes, France. For info.: Sonja Craythorne, Dept. of Anesthesiology, Univ. of Miami, Miami 33101, (305) 547-6411.

Coronary Artery Disease and Sudden Death: Primary and Secondary Prevention, June 14-16, Hyatt Grand Cypress, Orlando. For information: Margaret Kleiger, 64 Inverness Dr. E., Englewood, CO 80112, (303) 790-8445.

10th Annual Florida Suncoast Pediatric Conference, June 15-19, Sheraton Sand Key Hotel, Clearwater Beach. For information: Gilbert Pitisci, M.D., 2902 Beach Dr., Tampa 33609, (813) 870-3720.

JULY

Vascular and Pulmonary Disease: Diagnosis and Management, July 26-28, Orlando Hyatt, Kissimmee. For information: Stephen Mattingly, 5808 S. Rapp Street, Littleton, CO 80120, (303) 798-9682.

Heart Answers

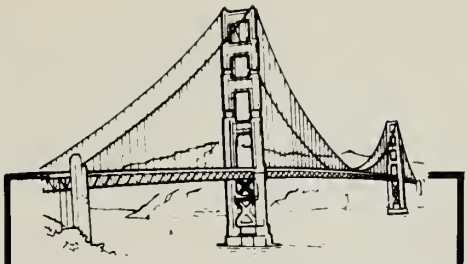


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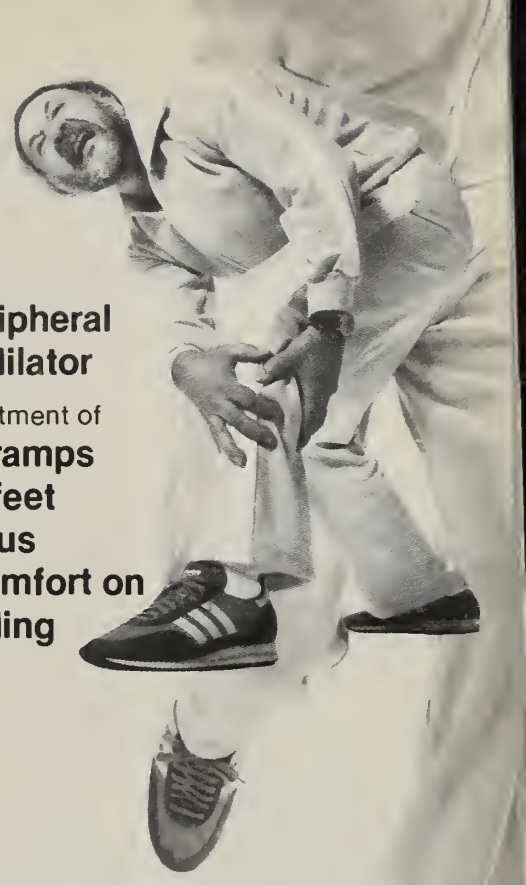
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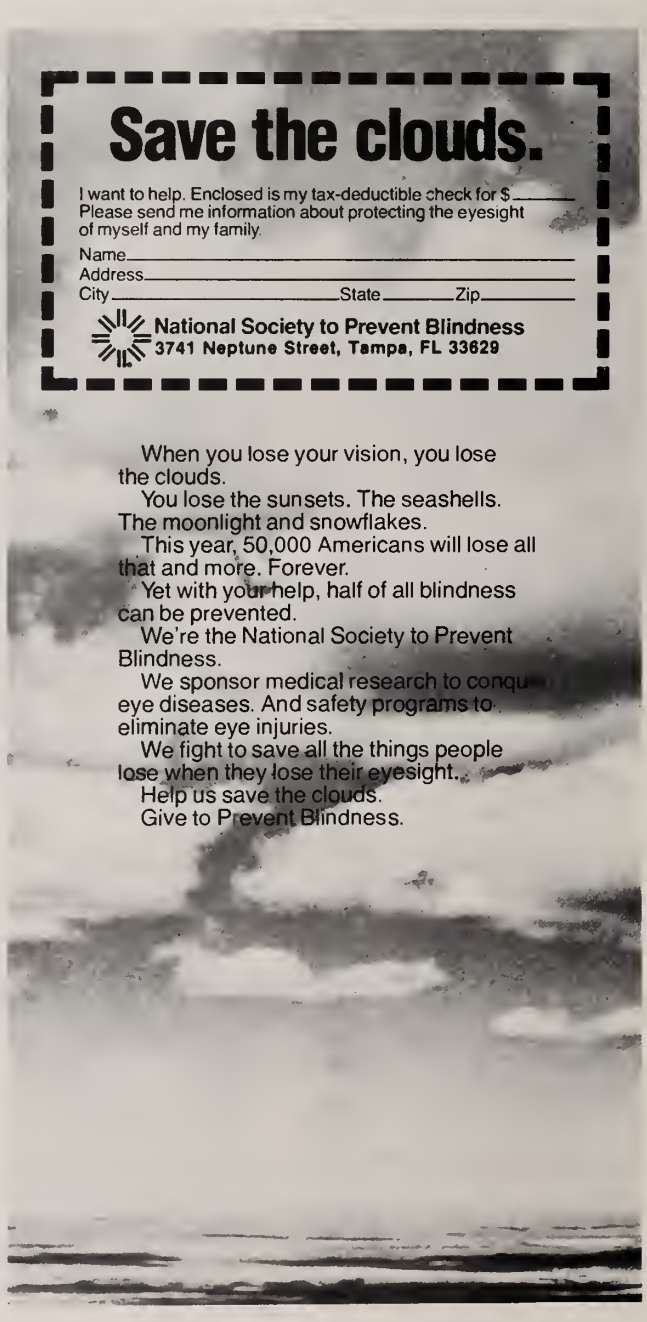
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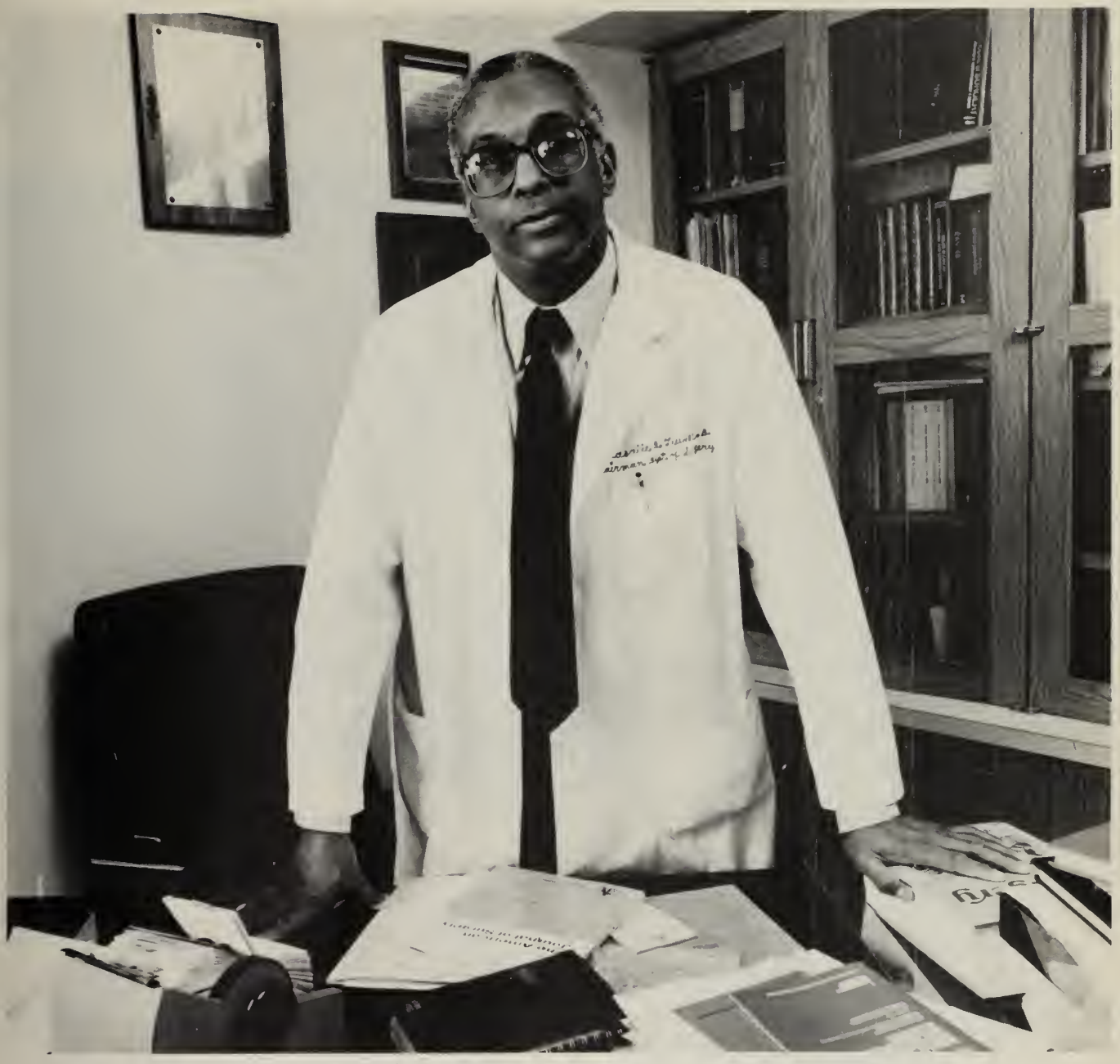
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"If more people had colorectal cancer checkups, more people could be cured," says Dr. LaSalle D. Leffall, Jr., M.D., F.A.C.S., Professor and Chairman of the Department of Surgery, Howard University Hospital, Washington, D.C. "It's that simple. You can't cure it if you don't know you have it." But if it's detected early, the cure rate for colorectal cancer is very high. Your doctor can perform the digital and proctoscopic exams, and you take care of the simple stool blood test at home.

The present cure rate is 44%. We believe it could be at least 31% higher. Since men and women are equally affected by this disease, we urge everyone over 50 to get regular checkups at the intervals specified in the box on the right.

Fact is, there will be 130,000 new cases of colorectal cancer this year. You can help us cure 75% of them.

If you are not in the age group affected, please pass this information on to someone you know who is. The warning signs for colorectal cancer are: a change in bowel habits and blood in the stool.

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Help us raise the cure rate.

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- Digital exam every year
- Stool blood test every year
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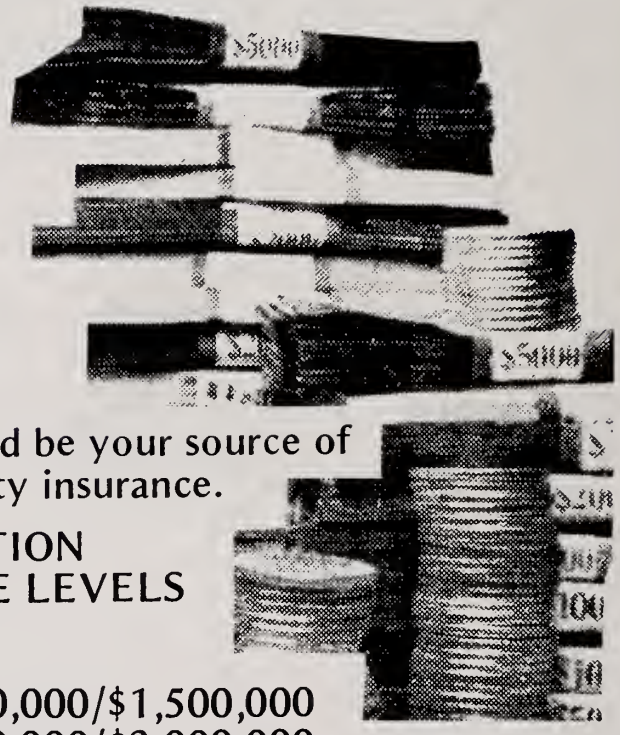
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Summary FMA Leadership Conference February 1-3, 1985 "Quality Medicine in a Rapidly Changing Environment"

The 1985 FMA Leadership Conference was conducted Friday, Saturday, and Sunday, February 1-3 at the Tampa Airport Marriott Hotel. "Quality Medicine in a Rapidly Changing Environment" was the Conference theme which offered county medical society leaders and others a comprehensive look at a wide array of issues including legislation, public relations, medical economics, and hospital medical staffs. Several general sessions highlighted the Conference along with a special "Leadership Skills Seminar for Women Physicians" and an outstanding scientific section on "Clinical and Fundamental Approaches to Cellular Engineering."

Registered attendance totaled 329 physicians, Auxiliary members and other guests. Physician registrants represented 23 county medical societies and 11 FMA recognized specialty groups.

The following are highlights of the major issues addressed and examined at the Conference:

Leadership Skills Seminar for Women Physicians

For the first time, the Leadership Conference offered a Leadership Skills Seminar for Women Physicians which was held on Friday morning and sponsored by the FMA Committee on Membership Development. The basic message conveyed by the various speakers was that women physicians have an unprecedented opportunity to be influencial and to assume leadership roles within organized medicine. "As physicians who are women, we must accept our responsibilities in this great profession of ours," Palma E. Formica, M.D., of New Brunswick, NJ, exhorted an audience of about 80 female physicians. She is a member of the American Medical Association House of Delegates and a member of the AMA Council on Long Range Planning and Development.

Noting that the ranks of United States women physicians have burgeoned from 13,000 in 1966 to 65,000 last year, Dr. Formica lamented that "we are growing in numbers but we are not growing in our responsibilities."

Only 26% of the nation's women physicians belong to the AMA, she said, even though the AMA has developed many programs for their benefit. Five women served as AMA Delegates and Alternates in 1978, and there are five Delegates and 15 Alternates this year. "Only you in your state can send a delegate to the AMA," Dr. Formica said. "Those women who are leaders must be role models for those that follow us."

Another guest speaker, Patricia J. Stuff, M.D., of Bonduel, WI, said the formula for leadership is a mixture of competence and power and influence, and all this adds up to success.



Palma E. Formica, M.D. speaks at the Leadership Skills Seminar for Women Physicians.

Dr. Stuff, a family physician who once served as Speaker of the House of her state medical society and who serves as an AMA delegate, gave some specific pointers for women who want to become more involved in organized medicine. "Train to be a good (media) interview," she advised, "and keep one professional name throughout your career." "Avoid being a one-issue person or candidate. You will be identified with that one issue. Share your desires and ambitions with more than one person. Be assertive and initiate action." Service and other organizations are always looking for free speakers and women should take advantage of these opportunities by volunteering when medical speakers are sought. "Do not be afraid of going it alone socially" she said to those women who are uncomfortable arriving at a social event unescorted.

Speaking on stress and burnout, Dolores A. Morgan, M.D., of Miami, said the number one problem she sees in treating physician patients is that "physicians use their time to minister to others' needs and ignore their own." "You have got to take care of yourself," she said. "No one else will." Asserting that "personal apppearance has a lot to do with how you feel," Dr. Morgan said women physicians should pay particular attention to their hair, make-up, and their clothes. Women physicians should empathize with their patients and when appropriate, share their emotions. "We should not be hesitant about expressing our feelings," the Impaired Physicians Program Medical Director concluded.

State Representative Bernard Kimmel, M.D., of West Palm Beach, and Gerold L. Schiebler, M.D., a registered lobbyist in the Florida Legislature, teamed up to encourage women to become more actively involved in the legislative process. Dr. Kimmel acknowledged that most legislators "have a dim view of doctors" and said that women are in a good position to alter that image. "Be involved on a year round basis," he suggested. "Keep the lines of communication open." He advised against writing form letters to legislators in support of or in opposition to issues, and he said "everyone should run for public office at least once."

"You can make a lasting and continuing contribution to FMA's lobbying efforts," said Dr. Schiebler, Professor and Chairman of Pediatrics at the University of Florida College of Medicine in Gainesville. "Women M.D.s have shown increased effectiveness," he said, "and I believe that you can be equally or more effective legislatively (compared with men)." The Florida Senate is now one-quarter women, he said, and most are highly competent and intelligent. The House has 20 female members for a total distaff contingent numbering 32 in both houses. In dealing with the Legislature, Dr. Schiebler advised women physicians to be informed and professional, to know what they are talking about, to be patient and willing to wait, to recognize the importance of the legislative staff, to be thankful for access, to refrain from anger if the legislator is not in agreement, and to be there when the Legislature is voting.

The half-day conference was planned and chaired by Kay K. Hanley, M.D. of Clearwater, and Margaret C. S. Skinner, M.D., both members of the FMA Committee on Membership Development.

FMA and FMA-A sponsor workshops on Parliamentary Procedures and How to Deal with the Media

Rufus K. Broadaway, M.D., Registered Professional Parliamentarian and author of *How to Run a Medical Meeting* discussed such topics as debating, taking a vote, determining a quorum, the type of motions, the order of business and general strategy carried out during a meeting. Assisting Dr. Broadaway at this well-attended and highly successful workshop was Franklin B. McKechnie, M.D., Vice Speaker of the FMA House of Delegates.

Another workshop on "How to Deal with the Media" was conducted by Mr. Clarence Jones, of Marathon, nationally recognized broadcast journalist, investigative reporter, author, and the only reporter who has ever won three duPont-Columbia Awards (broadcasting's equivalent of the Pulitzer) in 1975, 1978, and 1981. Following his entertaining style, Mr. Jones involved the audience in interviewing

techniques and coached physicians and auxilians on how to speak before the camera. "Try to get across just one thought and use just one sentence" he recommended. "Most on-camera responses are rarely over ten seconds, but you can easily get your message across in that period of time." Mr. Jones cautioned that before the camera one of the greatest mistakes made is attempting to say too much.

Scientific Section

A Friday afternoon scientific section on "Clinical and Fundamental Approaches to Cellular Engineering" was presented by Robert A. Good, M.D., Ph.D., Professor of Pediatrics and Graduate Research Professor at the University of South Florida College of Medicine. The world-recognized immunologist, researcher, teacher and pediatrician presented an exciting program on recent developments in cellular engineering which are having an impact on the treatment of such diseases as cancer and diabetes. Dr. Good emphasized the future direction of research he will be conducting as Physician-in-Chief and Chairman of the USF Department of Pediatrics at All Children's Hospital.

FMA President Frank C. Coleman, M.D. opens General Session

Saturday morning began with welcoming remarks from FMA President Frank C. Coleman, M.D. who introduced the keynote speaker at the First General Session. Dr. Coleman welcomed Paul Starr, Ph.D., Professor of Sociology at Harvard University and author of the bestselling book *The Social Transformation of American Medicine*. Dr. Starr told the audience about the frustration the public is experiencing over the health care system. Much of the frustration and confusion is due to competition and the rapidly changing redistribution of services. Traditional boundaries between adjacent groups such as insurance companies, hospitals and physicians are becoming blurred. New suppliers are taking away patients from private physicians. Although hospitals still accept individual patients from individual physicians, the same hospitals are getting more patients from so-called bulk purchases through a variety of prepaid plans. The future holds enormous corporate upheaval with the rapid growth of health care systems, the vertical integration of services into single organizations and diversification of traditional health care organizations into other health-related and non-health-related businesses.



Frank C. Coleman, M.D. opens General Session.

The second General Session on Saturday afternoon included a stimulating presentation on Doctor-Patient Communications. Featured speaker was David Pendelton, Ph.D., Professor at Kings Fund College in London. Dr. Pendelton's major theme was how physicians can improve their communication skills to produce more satisfied patients.

Workshops offered on Legislation, Public Relations, Medical Economics and Hospital Medical Staffs

Legislation • FMA Council on Legislation Chairman Louis C. Murray, M.D. opened the Legislation workshop by outlining the major legislative areas of concern in 1985. Professional liability remains as the number one concern of physicians at both the national and state levels. Several approaches to the problem are expected to be proposed in the upcoming legislative session which include tort reform and a modified workers' compensation approach. The constitutional amendment route still remains a viable approach if the problem is not satisfactorily resolved this year. Other major areas of concern include the Pharmacy Health-Care Consultant Bill, staff privileges for non-physicians, use of drugs by optometrists, health insurance coverage for chiropractors, and the issues relating to foreign medical graduates.

Dr. Alvin Smith of Volusia County offered an enthusiastic challenge to county medical societies to get organized, examine the issues, and communicate. He urged county medical society leaders to choose key contact physicians who are knowledgeable and willing to make the necessary calls.

FMA Auxiliary State Legislation Chairman Carolyn Spore stressed the importance of Auxiliary involvement in legislative efforts. Mrs. Spore outlined the development of the Auxiliary and told the audience that auxilians are knowledgeable, intelligent and extremely concerned about the issues. Auxiliary support and involvement in Tallahassee and the local community is an invaluable resource.

FMA Deputy Executive Director for Legislative and Public Affairs Scotty Fraser presented an overview of upcoming efforts toward tort reform. Mr. Fraser warned the audience that FMA efforts on professional liability have too often been seen as inflexible and a more flexible approach must be adopted to be successful.

Senator George Kirkpatrick (D-Gainesville) provided an entertaining and highly informative presentation on "Communicating with the Legislator." Senator Kirkpatrick told county medical society and Auxiliary leaders that most legislators have a negative perception of physicians and while their impressions are not always accurate, he warned that "perception is reality." Physicians have a difficult job ahead trying to improve their image in Tallahassee but improved communication is the key. Organized medicine can do much to improve its image and effectiveness through support of issues which do not affect the physician's pocketbook.

Public Relations • A public relations workshop was narrated by FMA Public Relations Officer, Robert E. Windom, M.D..

Featured on the program were Roy Pfautch, President of Civic Services, Inc. of St. Louis and Washington, DC; Jane Coughlin, Director of Consulting Services for the American Medical Association; Hank Drane, FMA Media Consultant, and representatives of county medical societies involved in public relation programs.

The workshop gave Roy Pfautch, who has assisted FMA with public information projects for the past decade, an opportunity to respond to criticism of FMA television advertising in the Reason '84 campaign. The complaint was that plaintiffs attorney ads opposing Amendment 9 appeared to be more numerous and effective than the Reason '84 ad boosting the Amendment. Mr. Pfautch explained that television spots during a campaign are most effective in influencing opinion during the final ten days of the campaign. The cream of Reason '84 TV spots never ran, he said, because of the Supreme Court action in removing Amendment 9 from the ballot a month before the general election.

Ms. Coughlin reported on a number of public relations programs sponsored by the AMA and local medical societies throughout the nation and the effectiveness of these ads and programs in educating the public on the positive activities in which the medical profession is involved. Advertisements and campaigns were shown on a television monitor for dicussion.

Mr. Drane outlined briefly the contents of an FMA Public Relations Guide which was written and published by FMA in 1983. Copies of the Guide were distributed to participants. Mr. Drane said additional copies were available to local doctors and medical societies upon request to the Jacksonville office. The Guide explains how to effectively deal with the media in setting up news conferences, editorial board meetings, interviews, and responding to criticism in letters to the Editor columns. Included also are tips on better writing and how to improve the chances of your news releases being printed.

An outstanding feature of the workshop was a series of briefings by representatives of six county medical societies and associations on public relations programs they have initiated. FMA would appreciate reports from other societies who are engaged in PR programs that have strengthened relations with citizens and the media in their areas, so that this material can be passed on to all members of organized medicine throughout the state. The various groups participating and a summary of these programs include:

Alachua County Medical Society: Peggy J. Davenport, Executive Director, outlined her society's "work-day" program in which leading citizens are invited to make the rounds with a local doctor to observe the profession in action. The Society has been rewarded with 33 work-day success programs, she reported.

Sarasota County Medical Society: Michael W. Bryant, M.D., President of the Society, and Marcia Gordon, Executive Director, briefed participants on a Medical Index Panel in cooperation with The Northern Trust Bank. Five panel programs on health care have been held which were open to the public and attendance has ranged from 70 to more than 120.

Duval County Medical Society: Carolyn Kirkland- Webb, PR Officer, explained how local doctors, along with the *Jacksonville Journal*, are writing a "health line" column for the *Journal's* weekly health care page. Response from readers and local doctors has been highly gratifying, she said.

Hillsborough County Medical Association: Pat Driscoll, PR Officer, briefed the audience on the new look and success of the *Hillsborough County Medical Association Bulletin*, which has been redesigned and expanded in size. The magazine is not only attracting new readers but advertising revenues average $2,500 monthly.

Escambia County Medical Society: Although no representative of the society spoke at the workshop, copies of its "Guide to Pensacola Health Services and Facilities" were available for inspection. The Guide is published in the *Pensacola News-Journal* periodically as a supplement. Cooperating with the society in publishing the guide are four area hospitals, various organizations and industries.

Dade County Medical Association: The Association has organized a media advertising campaign, chiefly to provide information on HMOs, PPOs and other health care data. A recording is available to callers who respond to the advertising campaign. Speaking on behalf of the Association at the workshops were Harold Norman, M.D., President-Elect and Patricia Handler, Assistant Executive Vice President.

Medical Economics • Charles P. Hayes Jr., M.D., Chairman, FMA Committee on Peer Preview Organizations, served as moderator of a program entitled "Changes in Health Economics and Organizations" presented by William D. Fullerton, Adjunct Associate Professor, University of North Carolina College of Medicine at Chapel Hill, and Principal Officer in the consulting firm of Health Policy Alternatives, Inc., Washington, DC. Mr. Fullerton stated that personal health care expenditures for Americans in 1980 were $215 billion dollars, that for 1985 the projected costs are estimated at $390 billion dollars, and for 1990 costs would reach $675 billion dollars. These costs are contributed to a very large extent by the four major players in health care: 1) Buyers; 2) Insurers; 3) Patients; and 4) Providers.

The buyers of health care services are business, government and individuals. All three are finding themselves in an ever increasing competitive market as well as traditional health care insurers. Employers are trying to hold down costs, but insurers are still paying about 31% of health care bills. Changes in the patient population will have a major impact on health care costs. Almost all net increases in services will be due to the growing population over sixty-five. Providers are experiencing a significant reduction in utilization due primarily to prevention programs and alternative delivery systems.

Mr. Fullerton summed up by stressing that physicians must join together in order to compete with the market forces that are impacting on the buyers, insurers, patients, and providers of health care services. Knowledge of the economics involved and market forces are essential in order for an informed professional organization to deal effectively with the future that awaits.

Hospital Medical Staffs • Thomas M. Daniel, M.D., Chairman, FMA Council on Hospital Medical Staffs, moderated a program entitled "Current Future Trends in Hospital Medical Staffs." Featured speaker was Thomas R. Reardon, M.D., AMA Delegate from Oregon to the Hospital Medical Staff Section. The discussion at the workshop centered on the development of the FMA Council on Hospital Medical Staffs and how the Council will be operating within the FMA structure. Dr. Reardon discussed current trends of Hospital Medical Staffs on a national level including future trends in Hospital Medical Staffs relations. He also presented an overview on Hospital Medical Staffs needs including the participation in developing AMA policy, education and information, providing a forum for discussion, and providing leadership, direction and representation. He discussed current government reimbursement programs and future increased regulatory activity by the Health Care Finance Administration. Dr. Reardon commented on how hospitals are becoming larger and more complex and are providing more intensive medical activities. He also discussed the role of JCAH and future hospital management. Problems physicians are facing include receiving less authority and respect, lack of effective relationships with their hospitals, being forced to develop cost containment programs as well as the practice of defensive medicine to offset the malpractice crisis. Other issues discussed included the expansion of HMOs and PPOs, joint ventures with hospitals and physicians, increased roles of peer review organizations and hospital management, the professional liability crisis, the Medicare fee freeze, and privileges for limited license practitioners.

Dr. Daniel provided information on the development of the Florida Medical Association's Council on Hospital Medical Staffs and reviewed the goals and objectives of the Council. He also discussed the recent recommendation of the Council to the Board of Governors to encourage county medical societies to develop local Hospital Medical Staffs Committees to provide a forum for the discission of issues on a local level in addition to increasing bi-directional communications between the local county hospital medical staffs and state council. Further discussion centered on the importance of the Council encouraging participation from Hospital Medical Staffs physicians that are not currently members of the FMA.

President's Prayer Breakfast

The Reverand H. William Vassey of the Village Presbyterian Church in Tampa presented the invocation before a large audience of county medical society and Auxiliary leaders. James Strange, Ph.D., Professor of Religious Studies and Dean, College of Arts and Letters, University of South Florida, pre-

sented an interesting and unusual talk entitled "Biblical Meditation." Following an overview of traditional forms of meditation and their benefits, Dr. Strange promoted a new form of meditation which relies on biblical affirmations. This new meditation offers physiological and emotional benefits at least as effective as other forms of meditation.

Final General Session focuses on Legislation

Luis M. Perez, M.D., FMA President-Elect opened the final General Session of the 1985 Leadership Conference before a standing room only audience. Welcoming remarks followed by Louis C. Murray, M.D., Chairman, FMA Council on Legislation who introduced the first speaker, FLAMPAC President, Robert E. Windom, M.D.

Dr. Windom's presentation was entitled "Prescription for Success," in which he identified areas where FLAMPAC activity has been successful. He pointed out that physician candidates had been successful as members of the Legislature. They are Senator "Doc" Myers, Representative Bernard Kimmel, Representative David Thomas and Representative Betty Metcalf who is a wife of a physician. Dr. Windom said that the best prescription for success, for improving the health of FLAMPAC, is for the membership and their spouses in the Auxiliary to become involved in the political process, either as candidates themselves or as active campaigners for others.



Luis M. Perez, M.D., FMA President-Elect opens the final General Session.

The Honorable William G. "Doc" Myers, M.D., State Senator (R-Tequesta) next addressed the audience by speaking about "Non-professional Liability Issues." Senator Myers pointed out that many allied health professionals are very envious of physicians as the leader of the health team. Therefore, there is a continual onslaught of legislation infringing upon services that only physicians are qualified to deliver. For example, there is currently legislation proposing that pharmacists be allowed to prescribe certain medications; addition of disciplines to hospital staff other than physicians, such as nurse anesthetists, psychologists, and advanced nurse practitioners; and a chiropractic school. Other issues involve the Medical Practice Act sunset entailing increased disciplinary authority of the Board of Medical Examiners, the Mayo Clinic, foreign medical graduates and trauma centers.

The next speaker was John E. Thrasher, Esq., FMA Deputy Executive Director and General Counsel, whose presentation was entitled "Professional Liability 'What Do We Do Now?'" Mr. Thrasher said that it brought to the public's attention the seriousness and magnitude of the problem in Florida, which adversely affects not only physicians, but patients in general by increasing the costs of care. Mr. Thrasher further cited the insufficiences of the legal system in dealing with malpractice. There seems to be the expectation, he said, that in all medical procedures, the outcome will be favorable. Yet there are many new procedures and treatment modalities, that were once unheard of, which can continue life but are often performed on the elderly who otherwise would not be alive had there not been the tremendous strides in medical care. Therefore, the question becomes: "What is malpractice?" Mr. Thrasher concluded that the essence of the problem must be met by organized medicine with a sense of unity to preserve the right of patients to receive appropriate care; the sense among physicians that whatever risks they must take to save a life will not result in a law suit; and finally an understanding among the public regarding the tremendous advances in medical science and the myriad complexities involved in successfully administering that technology to people.

The final speaker was Senator Dempsey J. Barron (D-Panama City) who is Dean of the Florida Senate and has served longer than any other member Senator Barron began his presentation by asserting that the number one problem of this state and of this nation is the cost of the delivery of health care. And further, that this problem is not limited to this nation, but crossed boundaries and oceans around the world. Senator Barron feels that the resolution in Florida is to get professional liability out of the tort system, and that the only probable way this will occur is through a constitutional amendment.

Senator Barron said that for the legislature to resolve this issue, it would take the full active support of the Governor. The Senator revealed that he has a proposal which he will sponsor in the Senate, based on the Workers' Compensation approach. He made it clear that the likelihood of its passing both chambers of the legislature was remote at best. He said that there are two kinds of damage awards: special and general. It is the general damage awards that result in the large sums of money that we have heard about in malpractice cases. Therefore, cases should be limited to special compensation. General damages would include "pain and suffering," which is compensated for whatever amount a jury considers to be equivalent to pain and suffering.

In summary, it is clear that Senator Barron has assumed a leadership role in trying to resolve the issue of malpractice, but he cannot do it alone. Moreover, he challenged the medical profession to use its power and hammer home a resolution to the problem, which until now has been manipulated by the legal profession and not for the benefit of the patient or his family. With this political guidance, organized medicine must utilize its combined strength to remove this impediment to physicians attempting to improve the health status of their patients.

Leadership Conference Highlights







(1) Paul Starr, Ph.D. addresses the first General Session, (2) Guy T. Selander, M.D., FMA Vice Speaker; Roger A. Goetz, M.D., New Medical Director of Impaired Physicians Program, and Yank D. Coble Jr., M.D., Treasurer (3) Senator Dempsey J. Barron spoke on legislation; (4) FMA President Frank C. Coleman, M.D. speaks to FMA Media Consultant, Hank Drane (5) FMA Auxiliary State Legislation Chairman, Carolyn Spore.





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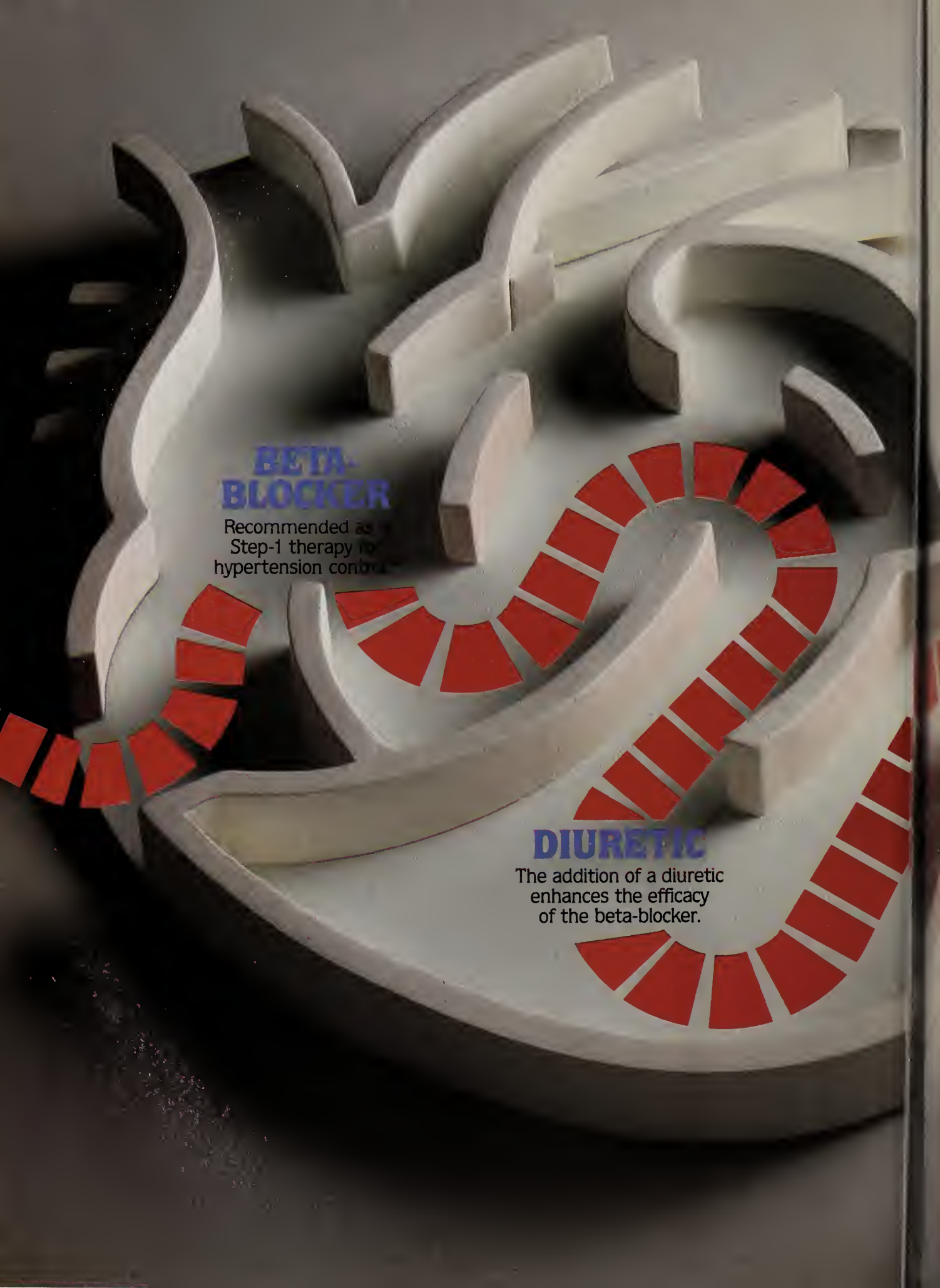
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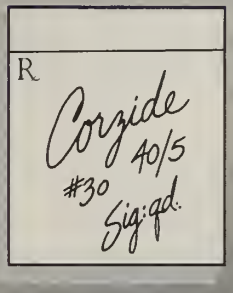
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*Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure. The 1984 report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure. Arch Intern Med 144:1045-1057, 1984.

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CONTRAINDICATIONS: Nadolol — Bronchial asthma, sinus bradycardia and greater than first degree conduction block, cardiogenic shock, and overt cardiac failure (see WARNINGS). **Bendroflumethiazide** — Anuria, and in those with previous hypersensitivity to bendroflumethiazide or other sulfonamide-derived drugs.

WARNINGS: Nadolol — Cardiac Failure — Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta-blockade may precipitate more severe failure. Although beta-blockers should be avoided in overt congestive heart failure, if necessary, they can be used with caution in patients with a history of failure who are well compensated, usually with digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle. IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta-blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, digitalize and/or give diuretics, and closely observe response, or discontinue nadolol (gradually, if possible).

Exacerbation of Ischemic Heart Disease Following Abrupt Withdrawal — Hypersensitivity to catecholamines has been observed in patients withdrawn from beta-blocker therapy; exacerbation of angina and, in some cases, myocardial infarction have occurred after *abrupt* discontinuation of such therapy. When discontinuing chronic use of nadolol, particularly in patients with ischemic heart disease, gradually reduce dosage over a 1- to 2-week period and carefully monitor the patient. Reinstitute nadolol promptly (at least temporarily) and take other measures appropriate for management of unstable angina if angina markedly worsens or acute coronary insufficiency develops. Warn patients not to interrupt or discontinue therapy without physician's advice. Because coronary artery disease is common and may be unrecognized, it may be prudent not to discontinue nadolol therapy abruptly even in patients treated only for hypertension.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA-BLOCKERS. Administer nadolol with caution since it may block bronchodilation produced by endogenous or exogenous catecholamine stimulation of beta$_2$ receptors. **Major Surgery** — Because beta blockade impairs the ability of the heart to respond to reflex stimuli and may increase the risks of general anesthesia and surgical procedures, resulting in protracted hypotension or low cardiac output, it has generally been suggested that such therapy should be withdrawn several days prior to surgery. Recognition of the increased sensitivity to catecholamines of patients recently withdrawn from beta-blocker therapy, however, has made this recommendation controversial. If possible, withdraw beta-blockers well before surgery takes place. In emergency surgery, inform the anesthesiologist that the patient is on beta-blocker therapy. Use of beta-receptor agonists such as isoproterenol, dopamine, dobutamine, or levarterenol can reverse the effects of nadolol. Difficulty in restarting and maintaining the heart beat has also been reported with beta-adrenergic receptor blocking agents. **Diabetes and Hypoglycemia** — Beta-adrenergic blockade may prevent the appearance of premonitory signs and symptoms (e.g., tachycardia and blood pressure changes) of acute hypoglycemia. This is especially important with labile diabetics. Beta-blockade also reduces release of insulin in response to hyperglycemia; therefore, it may be necessary to adjust dose of antidiabetic drugs. **Thyrotoxicosis** — Beta-adrenergic blockade may mask certain clinical signs (e.g., tachycardia) of hyperthyroidism. To avoid abrupt withdrawal of beta-adrenergic blockade which might precipitate a thyroid storm, carefully manage patients suspected of developing thyrotoxicosis.

Bendroflumethiazide — Use with caution in severe renal disease. In patients with renal disease, azotemia may be precipitated. With impaired renal function, effects of the drug may be cumulative. Use with caution in impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS: General — Nadolol — Use with caution in patients with impaired hepatic or renal function (see DOSAGE AND ADMINISTRATION).

Bendroflumethiazide — At appropriate intervals, perform serum electrolytes determination to detect possible electrolyte imbalance warning signs of which are dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and G.I. disturbances such as nausea and vomiting. Observe patients for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Drugs such as digitalis may influence serum electrolytes. Hypokalemia may develop, especially with brisk diuresis, in presence of severe cirrhosis. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Response of the heart to toxic effects of digitalis can be exaggerated with hypokalemia. Use potassium supplements such as high potassium foods to avoid or treat hypokalemia. Any chloride deficit is generally mild and usually does not require specific therapy except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction rather than salt administration except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain thiazide-treated patients. Latent diabetes mellitus may become manifest during thiazide therapy. Antihypertensive effects of bendroflumethiazide may be enhanced in the postsympathectomy patient.

Careful reappraisal of therapy and consideration given to withholding or stopping diuretic therapy is necessary if rising nonprotein nitrogen or BUN (indicative of progressive renal impairment) occurs. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Thiazides decrease calcium excretion. Pathologic changes in parathyroid gland with hypercalcemia and hypophosphatemia have been occasionally observed with prolonged therapy. Common complications of hyperparathyroidism have not been seen.

Information for Patients — Warn patients, especially those with evidence of coronary artery insufficiency, against interruption or discontinuation of nadolol without physician's advice. Although cardiac failure rarely occurs in properly selected patients, advise patients being treated with beta-adrenergic blocking agents to consult physician at the first sign or symptom of impending failure. Advise patients of proper course if dose inadvertently missed.

Laboratory Tests — Regularly monitor serum and urine electrolyte levels (see WARNINGS, *Bendroflumethiazide*, and PRECAUTIONS, *General, Bendroflumethiazide*).

Drug Interactions — Nadolol — When administered concurrently the following drugs may interact with beta-adrenergic blocking agents: **Anesthetics, general** — exaggeration of anesthetic-induced hypotension (see WARNINGS, *Nadolol, Major Surgery*). **Antidiabetic drugs (oral agents and insulin)** — hypoglycemia or hyperglycemia; adjust antidiabetic drug dosage accordingly (see WARNINGS, *Nadolol, Diabetes and Hypoglycemia*). **Catecholamine-depleting drugs (e.g., reserpine)** — additive effect; monitor closely for evidence of hypotension and/or excessive bradycardia.

Bendroflumethiazide — When administered concurrently the following drugs may interact with thiazide diuretics: **Alcohol, barbiturates, or narcotics** — may potentiate orthostatic hypotension. **Antidiabetic drugs (oral agents and insulin)** — thiazide-induced hyperglycemia may require adjustment of antidiabetic drug dosage. **Other antihypertensive drugs** — additive or potentiated effect. **Corticosteroids, ACTH** — intensified electrolyte depletion, particularly hypokalemia. **Ganglionic or peripheral adrenergic blocking drugs** — potentiated effect. **Pressor amines (e.g., norepinephrine)** — possible decrease response but not sufficient to preclude their use. **Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)** — possible increased response.

Drug/Laboratory Test Interactions — Discontinue thiazides before tests for parathyroid function (see PRECAUTIONS, *General, Bendroflumethiazide*).

Carcinogenesis, Mutagenesis, Impairment of Fertility — Nadolol — In 1 to 2 years oral toxicologic studies in mice, rats, and dogs, nadolol did not produce significant toxic effects. In 2-year oral carcinogenic studies in rats and mice, nadolol did not produce neoplastic, preneoplastic, or nonneoplastic pathologic lesions. **Bendroflumethiazide** — Long-term studies in animals have not been performed.

Pregnancy — Teratogenic Effects — Nadolol — Category C. In animal reproduction studies with nadolol, evidence of embryo- and fetotoxicity was found in rabbits, but not in rats or hamsters, at doses 5 to 10 times greater (on a mg/kg basis) than the maximum indicated human dose; no teratogenic potential was seen in any of these species. There are no well-controlled studies in pregnant women; therefore, use nadolol in pregnant women only if potential benefit justifies potential risk to the fetus. **Bendroflumethiazide** — Category C. Animal reproduction studies have not been conducted. This drug's effect on the fetus when administered to a pregnant woman or its effect on reproductive capacity is not known. Bendroflumethiazide should be given to a pregnant woman only if clearly needed. **Nonteratogenic Effects** — Since thiazides cross the placental barrier and appear in cord blood, weigh anticipated benefit of the drug in pregnant women against possible hazards to the fetus; these hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other reactions which have occurred in adults.

Nursing Mothers — Both nadolol and bendroflumethiazide are excreted in human milk. Because of the potential for serious adverse reactions in nursing infants either discontinue nursing or discontinue therapy, taking into account the importance of CORZIDE (Nadolol-Bendroflumethiazide Tablets) to the mother.

Pediatric Use — Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: Nadolol — Most adverse effects have been mild and transient and have rarely required nadolol withdrawal. **Cardiovascular** — Bradycardia with heart rates of less than 60 beats per minute occurs commonly, and heart rates below 40 beats per minute and/or symptomatic bradycardia were seen in about 2 of 100 patients. Symptoms of peripheral vascular insufficiency, usually of the Raynaud type, have occurred in approximately 2 of 100 patients. Cardiac failure, hypotension, and rhythm/conduction disturbances have each occurred in about 1 of 100 patients. Single instances of first degree and third degree heart block have been reported; intensification of AV block is a known effect of beta-blockers (see also CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS). **Central Nervous System** — Dizziness or fatigue reported in approximately 2 of 100 patients; paresthesias, sedation, and change in behavior reported in approximately 6 of 1000 patients. **Respiratory** — Bronchospasm reported in approximately 1 of 1000 patients (see CONTRAINDICATIONS and WARNINGS). **Gastrointestinal** — Nausea, diarrhea, abdominal discomfort, constipation, vomiting, indigestion, anorexia, bloating, and flatulence each reported in 1 to 5 of 1000 patients. **Miscellaneous** — Each of the following reported in 1 to 5 of 1000 patients: rash; pruritus; headache; dry mouth, eyes, or skin; impotence or decreased libido; facial swelling; weight gain; slurred speech; cough; nasal stuffiness; sweating; tinnitus; blurred vision. Although relationship to drug usage is not clear, sleep disturbances have been reported. The oculomucocutaneous syndrome associated with practolol has not been reported with nadolol. The following adverse reactions may also occur: **Central Nervous System** — reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss; emotional lability with slightly clouded sensorium, decreased performance on neuropsychometrics. **Gastrointestinal** — mesenteric arterial thrombosis; ischemic colitis. **Hematologic** — agranulocytosis; thrombocytopenic or nonthrombocytopenic purpura. **Allergic** — fever combined with aching and sore throat; laryngospasm; respiratory distress. **Miscellaneous** — reversible alopecia; Peyronie's disease; erythematous rash; arterial insufficiency.

Bendroflumethiazide — Gastrointestinal System — anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis. **Central Nervous System** — dizziness, vertigo, paresthesia, headache, xanthopsia. **Hematologic** — leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. **Dermatologic-Hypersensitivity** — purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis). **Cardiovascular** — orthostatic hypotension may occur. **Other** — hyperglycemia, glycosuria, occasional metabolic acidosis in diabetics, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

OVERDOSAGE: Nadolol may cause excessive bradycardia, cardiac failure, hypotension, or bronchospasm if overdosed. Overdosage of thiazides may cause lethargy, which may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function and without evidence of serum electrolyte changes or dehydration. Gastrointestinal irritation and hypermotility may occur. Transitory increase in BUN and serum electrolyte changes may occur, especially in patients with renal impairment.

Treatment — Nadolol can be removed from the general circulation by hemodialysis. In determining duration of corrective therapy, take note of the long duration of the effect of nadolol. In addition to gastric lavage, employ the following measures, as appropriate. **Excessive Bradycardia** — Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **Cardiac Failure** — Administer a digitalis glycoside and diuretic. It has been reported that glucagon may also be useful in this situation. **Hypotension** — Administer vasopressors, e.g., epinephrine or levarterenol. (There is evidence that epinephrine may be the drug of choice.) **Bronchospasm** — Administer a beta$_2$-stimulating agent and/or a theophylline derivative. **Stupor or Coma** — Supportive therapy as warranted. **Gastrointestinal Effects** — Symptomatic treatment as needed. **BUN and/or Serum Electrolyte Abnormalities** — Institute supportive measures as required to maintain hydration, electrolyte balance, respiration, and cardiovascular and renal function.

DOSAGE AND ADMINISTRATION: DOSAGE MUST BE INDIVIDUALIZED. Patients with renal failure require adjustment in dosing interval; see package insert for dosage in these patients.

Consult package insert before prescribing CORZIDE (Nadolol-Bendroflumethiazide Tablets).

HOW SUPPLIED: Available as scored tablets containing 40 mg nadolol combined with 5 mg bendroflumethiazide and 80 mg nadolol combined with 5 mg bendroflumethiazide in bottles of 100.

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This month's cover of *The Journal* is a drawing by Nickolas S. Petkas, M.D., Lake Park, depicting the theme of the lead article, "Percutaneous removal of kidney stones."

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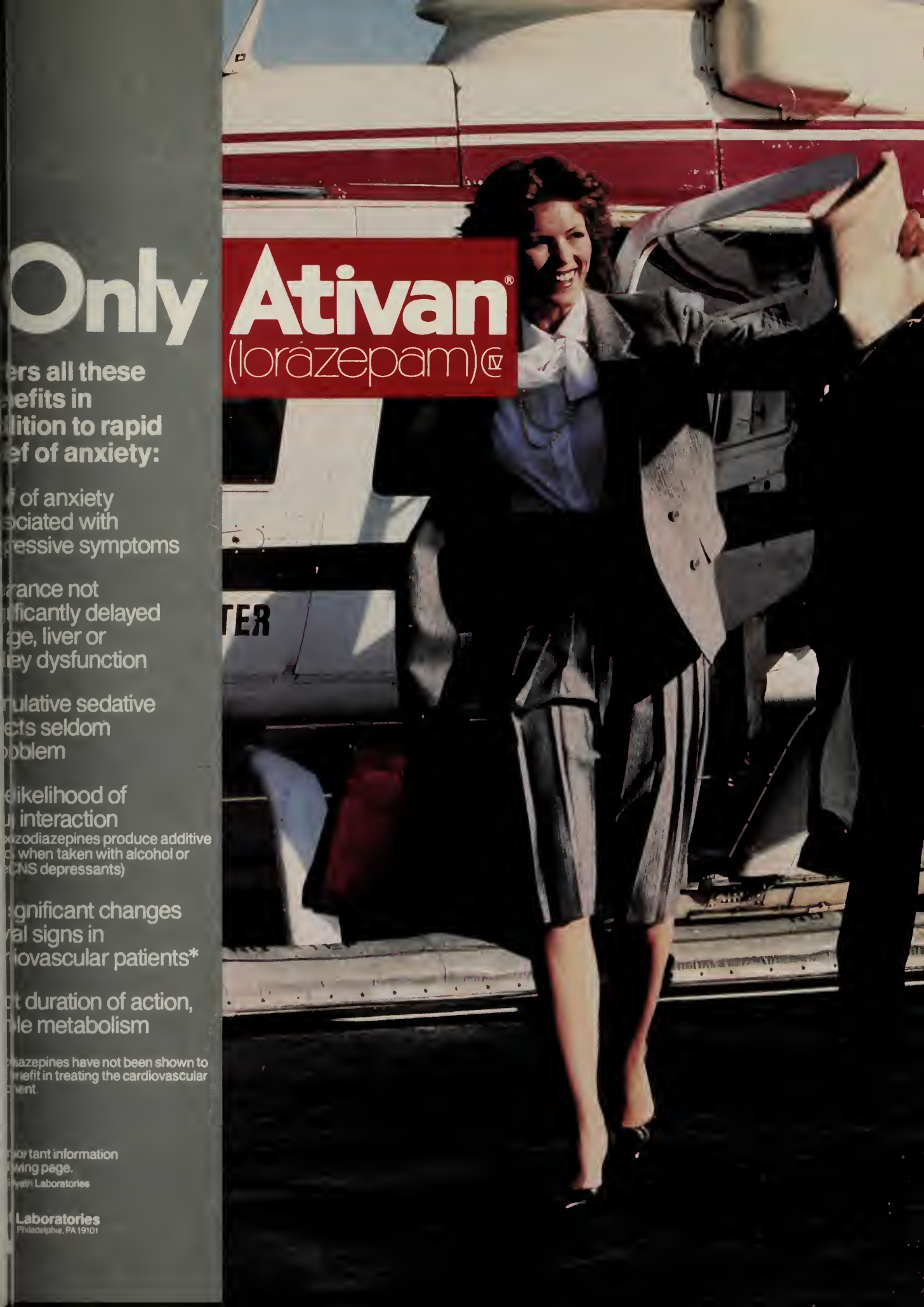
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Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia; some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

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DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

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FMA prepares to address the professional liability crisis in the 1985 Legislative Session



The 1985 Legislative Session of the Florida Legislature begins on April 2, 1985. The 120 representatives and the 40 senators will address many crucial issues affecting all the citizens of our state. Many of these issues will be related to the problems of growth in Florida as we face a population increase of about 62.5% by the end of this century. Other issues are directly related to health care and the Florida Medical Association will be in the forefront as these issues are addressed since they will affect the citizens of Florida and the ability of physicians to provide quality health care at the most reasonable cost possible and with ready access to our population.

The most important of these health issues remains the professional liability insurance crisis in our state. I am therefore devoting this monthly message to this crucial issue, which is having such a devastating effect on the cost, quality and access to health care. James Harold Thompson, the new Speaker of the House of Representatives, and Harry Johnston, the new President of the Senate, are both lawyers. However, both have expressed concern about the malpractice insurance problem and have indicated that the Legislature must do something to deal with it.

Special committees have been appointed in the Senate and the House. The Senate Committee is chaired by Senator Dempsey Barron, and its principle responsibility involves the malpractice insurance problem. The House Committee is chaired by Representative Tom Gustafson and has broader charge that requires an examination of pressing problems in the health care delivery system, including professional liability.

As your President, I have met with Governor Graham, the President of the Senate, the Speaker of the House of Representatives, Committee Chairmen Barron and Gustafson, Insurance Commissioner Bill Gunter, and representatives of the hospital association, the insurance industry, the business community, the American Association of Retired Persons, the Florida Bar Association, and the Florida Academy of Trial Lawyers. I have appeared as a witness before the two task forces that have been studying the professional liability problem over the past several months. The first of these task forces was one representing the six business coalitions for health in Florida. Serving on this task force were representatives of some of the largest businesses in our state. After attending several meetings and receiving statements from many witnesses, the business coalition task force has prepared a report which contains recommendations that have now been converted into legislative language for submission to the Legislature. These recommendations include the following:

Strengthening the ability of the State Board of Medical Examiners to deal with bad doctors and to ensure that foreign medical graduates have adequate medical training.

Mandating professional liability insurance coverage for all physicians in the minimum amount of $150,000 per claim, and $450,000 per year.

Mandating twelve hours of continuing medical education during the previous 24 months and an additional three hours of continuing medical education in the area of risk management.

Expanding the energies required to report disciplinary action against physician's staff members to include HMOs and Ambulatory Surgical Centers.

Eliminating the doctrine of joint and several liability.

Mandating the establishment of internal risk management programs in all hospitals which must include a position on the Risk Management Committee.

Changing the standard of proof in medical malpractice actions from "the greater weight of the evidence" to "clear and convincing evidence."

Requiring that medical experts in medical malpractice cases must have been engaged in the practice of the teaching of medicine within the 24 month period preceeding the alleged act of malpractice.

Placing a limit of $500,000 on non-economic damages (excluding punitive damages) in any medical malpractice case.

This task force has also recommended the Legislature study an appropriate limit to be placed on contingency fees, or as an alternative, that the Legislature adopt an appropriate resolution to the Florida Supreme Court requesting that the Court impose such a limitation.

The second task force, the Governor's Task Force on Medical Malpractice, was appointed by the Governor in response to a bill introduced by Senator Barron late in the 1984 Legislative Session (S-1022) that would establish a no-fault workers' compensation approach as a solution to the medical malpractice problem. This task force was charged by the Governor with examining all the issues relating to medical malpractice and with developing policy recommendations for addressing the legal, disciplinary, regulatory, financial and marketplace considerations necessary to assure a cost-effective, fair, and reasonable system of compensation for patients injured as a result of negligence by physicians within the framework of justice and reason. The task force has not yet completed its work but is expected to make a report to Governor Graham by April 1, 1985. Three physicians, George Crane, M.D., Spurgeon McWilliams, M.D., and Richard Hodes, M.D., have served with distinction as members of this task force.

The emphasis of the Governor's Task Force deliberations has been on alternative solutions to the medical malpractice problem, such as the workers' compensation approach, arbitration, and the use of screening panels. There are many people, including Governor Graham, who believe the medical malpractice problem can best be solved through alternative mechanisms rather than through modifyng the adversarial tort system. Studies are now underway to establish the cost of these alternative approaches.

The FMA's professional liability legislative program will be finalized following submission of the report and recommendations of the Governor's Task Force on Medical Malpractice. However, guidelines have been approved by the FMA Board of Governors for those concepts that should be included in meaningful tort reform legislation:

THAT THE FMA SUPPORT SOLUTIONS FOR RESOLVING THE PROFESSIONAL LIABILITY CRISIS THAT WILL ACHIEVE STABILITY IN RESPECT TO THE CURRENT COST OF PROFESSIONAL LIABILITY INSURANCE AND WILL PROVIDE TO PATIENTS WHO ARE TRULY INJURED IN THE MEDICAL SYSTEM AN OPPORTUNITY TO BE ADEQUATELY AND EFFICIENTLY COMPENSATED FOR THEIR INJURIES; AND FURTHER, THAT THE FMA SUPPORT THE FOLLOWING CONCEPT AS SOLUTIONS THAT MEET THE CRITERIA SET OUT ABOVE:

A) TORT REFORM PACKAGE
1. CAPS ON AWARDS
2. STRUCTURED SETTLEMENTS
3. ELIMINATE JOINT AND SEVERAL LIABILITY*, OR

B) ALTERNATIVE RESOLUTION FOR MALPRACTICE DISPUTES THROUGH ANY OF THE FOLLOWING, BUT NOT LIMITED TO:
1. MODIFIED "NO-FAULT" OR "WORKER COMPENSATION" APPROACH
2. ARBITRATION
3. SCREENING PANELS
4. "TRIP INSURANCE"
5. OTHER EFFECTIVE ALTERNATIVES THAT MIGHT BE IDENTIFIED.

C) ADDITIONAL CONSIDERATIONS
1. STRENGTHENING RISK MANAGEMENT PROGRAMS

2. STRENGTHENING THE ABILITY OF THE BOARD OF MEDICAL EXAMINERS TO DEAL WITH INCOMPETENT PHYSICIANS
3. CONSIDER THE FEASIBILITY OF MANDATORY INSURANCE FOR PHYSICIANS* (THIS CONCEPT IS LINKED SPECIFICALLY TO ITEM A(3) JOINT AND SEVERAL LIABILITY).

Several months ago the Florida Medical Association entered into an agreement with Dr. Henry Manne, Director of the Law and Economic Center at Emory University, Project Director, for carrying out an extensive research project on medical malpractice. We expect to have the results of these studies by April 1, 1985, so that the information will be available both to us and the Legislature this year. These studies include five parts.

First, an annotated survey of all the economic literature on and closely related to the issue of medical malpractice, studies on the number of malpractice suits and their outcome over a number of years, the relationship between malpractice recovery and insurance premiums, the distribution of malpractice recoveries involving different specialties in medicine, recoveries of abnormally high damages especially for pain and suffering, the distribution of these recoveries over different periods of time, the amount of actual negligence by a physician and a variety of other topics all addressed for the variety of techniques and approaches.

The second part of the report will be parallel to the first, but the emphasis will be on the scholarly literature that reports the effects of different specific policies that have been used to address the medical malpractice problem. These will include reports on efforts to cap malpractice recoveries, arbitration and other settlement processes, fine reviews, private contractual efforts as partial or total exculpation, strict liability (with or without specific damage limits), first party insurance programs and government insurance programs.

The third part of the report will be a critical survey of Florida law both in torts and contracts as it relates to medical malpractice.

The fourth part of the report will deal with insurance regulation in Florida and its relationship, if any, to the medical malpractice problem.

The final part of the report will be a descriptive catalog of every policy option available for dealing with the issue of medical malpractice. A unique feature of this catalog of options will be a measurement of how much or how little we know about the social and economic impact of each of the policy options.

Much of the information that will be contained in this important study is not, to the best of our knowledge, currently available anywhere and should therefore be of great value to everyone who is concerned about the medical malpractice problem.

The FMA will devote its fullest resources in seeking meaningful solutions to the professional liability cancer which is worsening almost daily in frightening proportions. As stated earlier, the FMA will face many other important issues affecting health care during the 1985 Legislative Session. In a previous report I described the reorganization of the Association's legislative arm. This reorganization is proceeding and should strengthen our ability to deal with these issues more effectively. However, more needs to be done, and we need your help. The revolution that is occurring with such rapidity in our health care delivery system requires the participation of every member of the FMA and the FMA Auxiliary. I hope that each of you will make a personal commitment to lend your active support for achieving success in our legisative effort.

Frank C. Coleman MD



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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae*) and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae,* staphylococci, and *S. pneumoniae*; Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli*, *P. mirabilis*, *Klebsiella* species, and enterococci (*S. faecalis*).

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

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Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Hematologic — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structure infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h). For dosage recommendations in patients with impaired renal function, consult package insert.

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

For full prescribing information, consult package insert.

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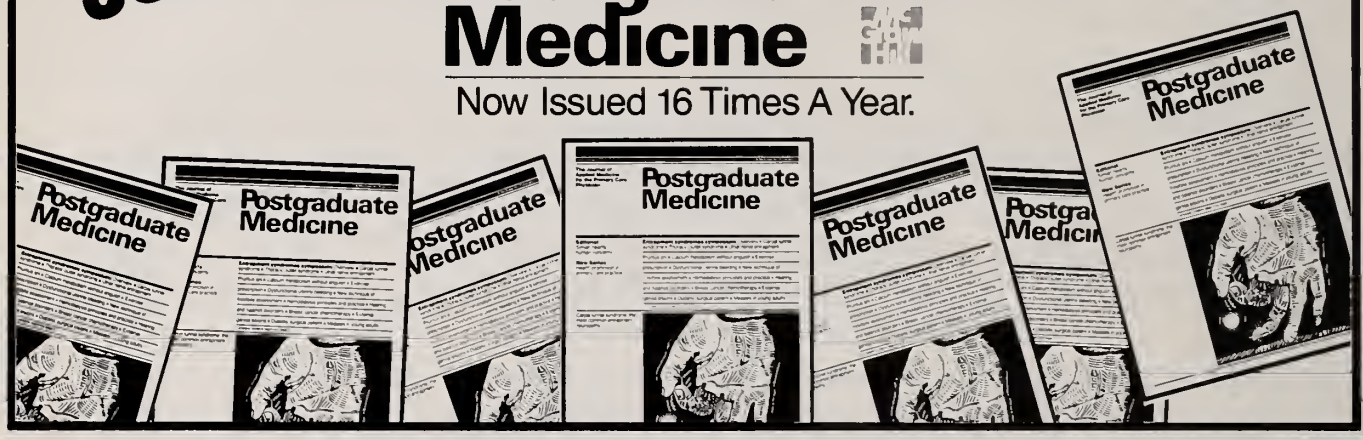
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EDITORIAL

The Health Care Consumer Protection and Awareness Act — a challenge

I had never thought of Florida as being a bellwether for any program of social change but the 1984 Legislature passed a bill that has been termed the most advanced and far reaching health legislation that has ever been passed by any state in the Nation. It is to be referred to as the "Health Care Access Act" and is important for the goals and policies it enunciates as well as for the specific actions it authorizes. It creates the Hospital Cost Containment Board and the Medical Public Assistance Trust Fund. These will prove to be powerful tools to shape the form of medical care.

Any attempt to condense 25 pages of fine print into a brief summary of high points is subject to valid charges of editorial license and I will not apologize for some personal interpretation, placement of emphasis, and perhaps even some out of context references. The alternative is for each person to read and study the bill, and I hope this stimulates just such action.

The Hospital Cost Containment Board has probably received the most early attention. It is made up of three providers, three purchasers of health care, and three consumers. Interestingly, none of the original appointees is a physician. The Board is given broad powers to advise the legislature, collect hospital and physician charge data, inform and educate the public, and approve or deny hospital budgets. Within the Board is an Office of Technical Assistance which is assigned to develop model insurance benefit packages, to assist employers in forming health coalitions, to serve as a clearing house for health delivery innovations, to enhance competition, to encourage the state prudent purchaser concept, and to work with existing coalitions and health councils. The Act places the Board in the Department of Insurance but transfers it to the Executive Office of the Governor effective December 31, 1985.

The Medical Public Assistance Trust Fund was established by an assessment on the net operating revenues of all hospitals, supplemented by a $20 million appropriation from state general revenue. The hospital assessment amounts to 1% of net revenue the first year and 1.5% in subsequent years. The Fund will be used to finance medical care, principally hospital, for an expanded indigent population. Medicaid eligibility will be expanded to include dependents under age 21 in intact families, unemployed parents and dependents under age 18, and married pregnant women. It establishes a medicaid medically needy program. Finally, and this will probably touch practicing doctors the most, it allocates $10 million from the Fund to assist county health units to establish primary care programs.

So much for the means by which actions are to be carried out. More revealing are the statements of legislative findings and intent. It is declared that *ACCESS* to *ADEQUATE* health care is a *RIGHT* which should be available to *ALL* Floridians. HRS is charged with improving the delivery of essential health services through long range planning and is instructed to replace or enhance existing delivery systems, when appropriate, with alternative delivery systems. The emphasis is to be on competition, efficiency, and cost effectiveness. The state is to act as a prudent purchaser in obtaining the services it is committed to provide.

There is a further mandate to HRS to be more active and definitive in long range planning regarding public health concerns such as water quality and threats to environmental health. However, in addition to these well recognized public health responsibilities, the Department is also authorized to assume the delivery of *PERSONAL* health services through the Public Health Units which are to expand their role in meeting community needs for primary care and nutrition programs.

This really only scratches the surface of the bill but it covers the elements that were the most revealing to me. The legislature evidently perceives a serious need of the people of Florida and believes that there has been an inability of the presently operating systems to satisfy it. That need is the accessibility and affordability of health care. I sense, also, an invitation to Medicine, perhaps even a plea, for cooperation and dialogue. There is a challenge here for the Profession to test whether other systems just might be able to do the job better. It isn't that changes may come. They have come and our challenge is to adapt to them while still preserving practice styles that assure high quality. Additionally, I see another challenge in the bill, this one to Society and its elected representatives to give these programs adequate financial and emotional support. If they do, then Florida might just be a bellwether. I know we can assure accessible and affordable care.

James K. Conn, M.D.
Tallahassee



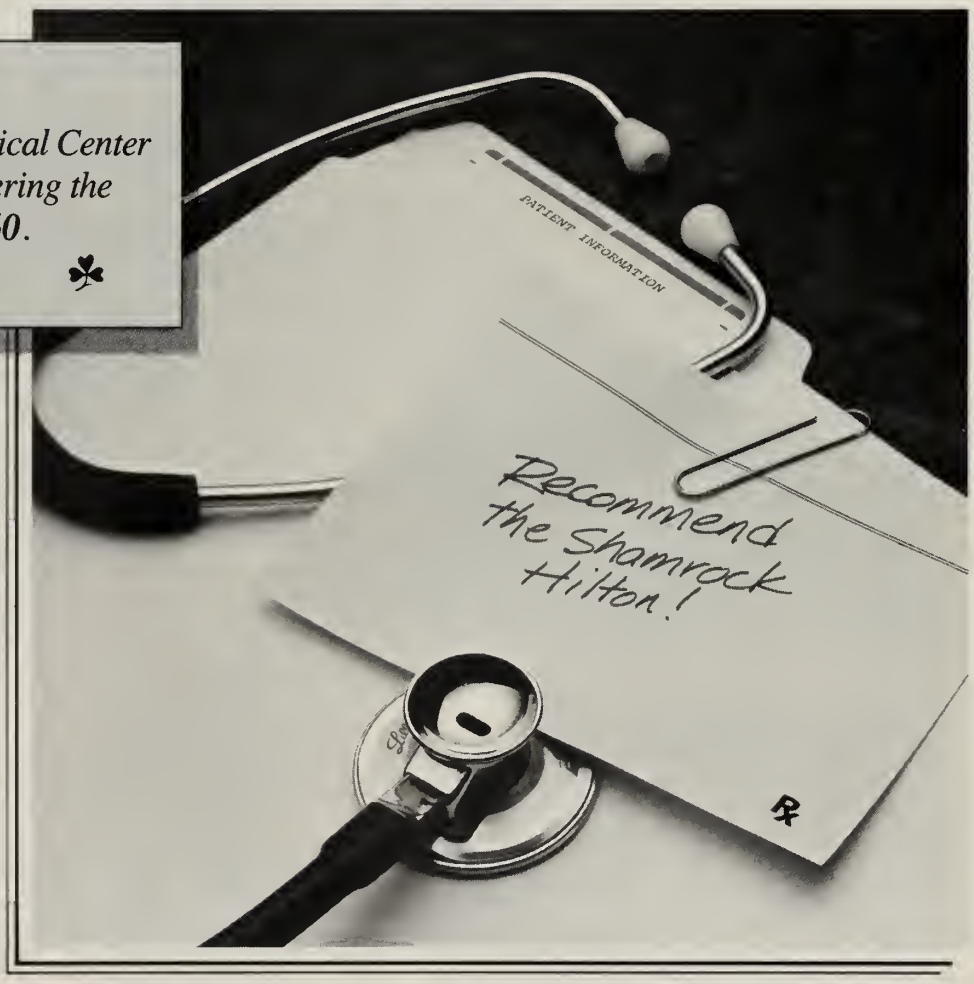
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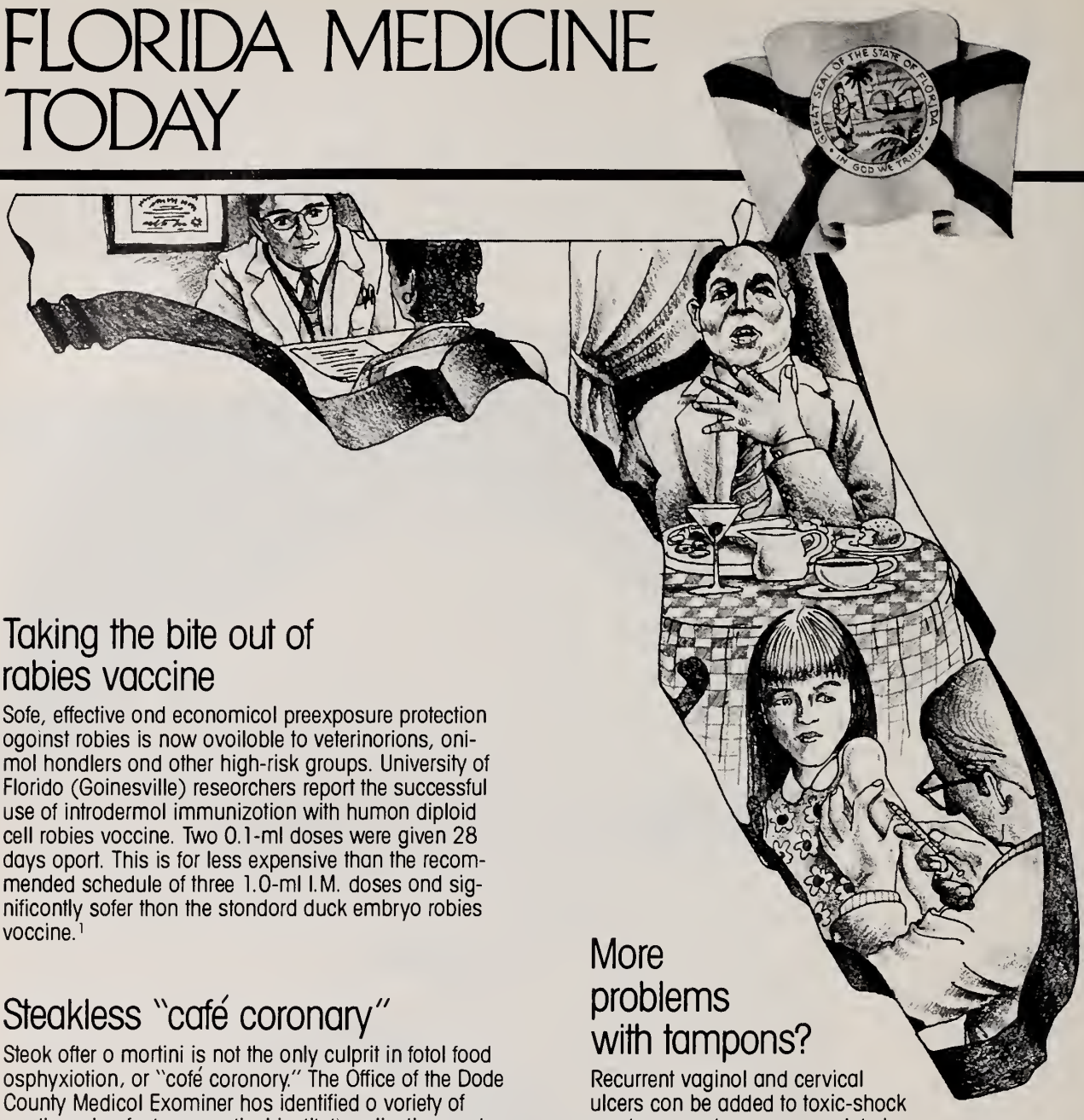
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FLORIDA MEDICINE TODAY



Taking the bite out of rabies vaccine

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Steakless "café coronary"

Steok ofter o mortini is not the only culprit in fotol food osphyxiotion, or "cofé coronory." The Office of the Dode County Medicol Exominer hos identified o voriety of predisposing foctors: medicol institutionolizotion, sedotive drugs, porkinsonism, old oge, poor dentition ond olcohol consumption. With institutionolized odults, friable foods not omenoble to the usuol rescue techniques ore often involved. Observers were present in o full 85% of fotol coses, indicoting o need for increased public oworeness. Instruments for retroction of foreign bodies should be mode readily ovoiloble ot public facilites ond nursing homes. And new techniques should be developed to deal with soft foods thot cannot be cleored by o grosping device or the Heimlich moneuver.[2]

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Percutaneous removal of kidney stones

James D. Daughtry, M.D., William J. Bean, M.D. and Bruce A. Rodan, M.D.

ABSTRACT: The advent of percutaneous stone manipulation offers a new approach to the removal of renal calculi. The techniques of removal through a nephrostomy site utilizing simple extraction, ultrasonic disintegration, chemolysis and combined procedures are presented. Systemic alkalinization of the urine or direct irrigation with bicarbonate or THAM solution through a nephrostomy tube may be used on a small percentage of stones which includes uric acid or cystine. Percutaneous removal of stones less than 15 mm is successfully performed using stone baskets, forceps or a flushing technique. Ultrasonic lithotripsy used in conjunction with the rigid nephroscope is a significant recent advance for removal of renal pelvic calculi. This is especially useful in the disintegration of calcium composite stones. The flexible nephroscope used with electrohydraulic lithotripsy gives an added dimension to approach stones in previously inaccessible areas. Well over 90% of all renal stones can be removed by the percutaneous approach.

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The advent of percutaneous stone manipulation offers a new approach to removal of renal calculi. It provides a new dimension for treatment of kidney stones.[1,2] Open surgical intervention, the standard technique, is no longer the sole method. Calculi in the renal pelvis and upper ureter can be removed through a nephrostomy site utilizing simple extraction, ultrasonic disintegration, chemolysis or combined procedures.

Three techniques will be discussed with emphasis upon ultrasonic lithotripsy because of its unique properties.

Techniques ● Stone dissolution has been used for several decades as a management of urolithiasis.[3] A small percentage of stones may be treated effectively including uric acid and cystine stones. Systemic alkalinization of the urine is the first line of therapy. If this is unsuccessful, a nephrostomy tube is inserted and direct irrigation with substances such as bicarbonate solution or a THAM solution is performed. Large uric acid renal pelvic stones may undergo dissolution in a matter of weeks. Problems include extravasation of the irrigating solution or electrolyte abnormalities. Although this has been used as a principal treatment, it is more commonly an adjunct to percutaneous stone manipulation or treatment for retained stones following ureterolithotomy.

Percutaneous removal of kidney stones can also be carried out through a nephrostomy channel using stone baskets, forceps or a flushing technique.[4,5] This is most applicable to stones less than 15mm in diameter or smaller than a nephrostomy channel. An advantage is that the stone can be removed under local or epidural anesthesia and has a low morbidity compared to the standard open surgical procedure.[6] The technique utilizes fluoroscopic guidance.[7]

A recent method of renal stone removal is ultrasonic lithotripsy used in conjunction with the nephroscope.[8] The advantages are: skin incision of only 1-2 cm, average hospital stay of 3-5 days, recuperative period of one week and minimal postoperative morbidity. In selected situations, this method represents a significant advance and is especially useful for calcium composite stones not amenable to dissolution, stones located in the renal pelvis, accessible infundibulum, or at the ureteropelvic junction. The flexible nephroscope in conjunction with electrohydraulic lithotripsy gives an added dimension to percutaneous nephrostolithotomy. Those stones previously inaccessible can be located and disintegrated with a shock wave created by the electrohydraulic lithotripter probe. Well over 90% can be removed by the percutaneous approach.

Prior to performing a percutaneous nephrostolithotomy the patient's diagnostic examinations, e.g. excretory urogram, are reviewed. The urologist and radiologist determine the proper placement of the nephrostomy tube and the appropriate method of extraction.[9] The first phase of the procedure takes place in the Radiology Department. In the fluoroscopy suite, with the patient in a prone position under local or epidural anesthesia, a percutaneous nephrostomy access is obtained by dilating the tract to the appropriate size, usually 26 French, using Teflon dilators or a balloon dilator. A large nephrostomy tube is left in and the patient is transferred to the surgical suite.

Using the fluoroscopic guidance of the C-arm, a working sheath is inserted and with the obturator is passed over the guide wire into the renal pelvis. The wire and obturator are removed and the nephroscope, with the ultrasonic lithotriptor, is placed in the sheath and locked in postition (Fig. 1). Inspection is performed taking care not to overdistend the pelvis. Specially designed forceps and basket extractors can be passed under direct vision through the nephroscope. Depending upon size of the scope, the operator decides whether to remove the stone mechanically or disrupt it with ultrasonic lithotripsy. Ultrasonic disintegration is carried out under direct vision using a video monitor with minimal trauma to the renal mucosal lining.

Intrarenal endoscopy is performed with continuous irrigation utilizing a warmed physiologic saline solution. If the calculus is not visualized, additional telescopes with 70 or 110 degree vision or a flexible nephroscope permits panoramic inspection of the internal renal structure. Once identified, the stone is directly contacted with the tip of the lithotriptor; the energy causes the stone to disrupt and fragment. Continuous suction through the probe clears the kidney of stone dust and smaller fragments while preventing spillage of calculus fragments into remote portions. The larger remnants are further

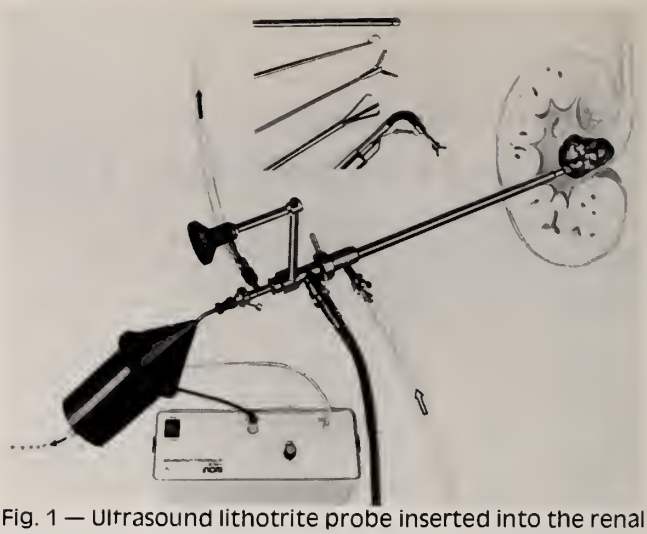


Fig. 1 — Ultrasound lithotrite probe inserted into the renal pelvis for disintegration of renal pelvic stones and removal of stone fragments by continuous suction. Other instruments such as flexible stone forceps, rigid triradiate stone graspers, fulgerating electrode and calyceal scalpel are useful adjuncts.

diminished until all debris disappears through the probe. As soon as inspection suggests complete removal, a plain radiograph is obtained to identify any retained stones and a nephrostogram is carried out to determine the patency of the ureter. A nephrostomy tube is left in place for 48 hours to allow irrigation of undetected debris.

This technique has several limitations. Direct inspection of all calyces is difficult and it may not be possible to remove small retained stones within narrow areas of the renal collecting system. Another theoretical problem involves the spillage of calculus fragments into the remote areas of the kidney or the ureter. In practice, however, continuous suction during disintegration has almost eliminated this problem. Inaccessible stones located in stenotic infundibulum or extensive staghorn calculi would probably be more expeditiously handled by an open surgical procedure. Another consideration would be that patients may require several sessions for complete stone removal, and the procedure time may equal that of an open surgical procedure.

In the past, this procedure was confined to patients unsuitable for general anesthesia or those with recurrent calculi which were difficult to manage by the standard techniques or to patients refusing open surgery. With advent of the nephroscope and ultrasonic lithotriptor, this procedure offers an alternative to open surgery. It is especially useful in patients with dilatation of the collecting system or those who have undergone previous stone surgery. Ureteral stones can be removed endoscopically utilizing similar techniques of basket extraction and ultrasonic lithotripsy.

Conclusion • The percutaneous technique represents a significant advancement over standard surgical methods in selected situations and results in

considerable savings in hospitalization and decrease in patient morbidity. There probably will be a broadening of the indications for percutaneous stone removal as we gain more experience. Adjuncts to this method, i.e. chemolysis for dissolution of retained particles and direct removal of small stones and particulate debris, make this procedure even more appealing. Patients with contraindications to open procedures or with previous multiple surgeries are ideal candidates for the technique.

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Management of diabetes in pregnancy

Kay F. McFarland, M.D.

ABSTRACT: The outcome of diabetic pregnancies has improved dramatically over the past 50 years.[1,2] *Changes in obstetrical practice, advances in neonatology, and more recently emphasis on good control of maternal blood sugar throughout gestation are largely responsible for this trend. Because perinatal mortality and neonatal morbidity are lowest when blood sugar levels are monitored frequently and kept as close to normal as possible,*[3] *the major recommendations regarding management of diabetes during pregnancy emphasize methods for normalizing glucose levels from the time of conception to delivery.*[4] *In addition careful prenatal assessment and expert care during the neonatal period will ensure the best possible pregnancy outcome.*

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The maternal mortality rate is low for both diabetic and nondiabetic women in the United States. However, morbidity associated with diabetic pregnancies is increased and relates more to an increase in the complications of pregnancy than to acceleration of diabetic complications. For example, there is a higher incidence of preeclampsia, polyhydramnios, and an increased cesarean section rate in diabetic pregnancies, but there is little evidence to suggest that the vascular complications of diabetes are increased during gestation. Pregnancy does not seem to worsen diabetic neuropathy and does not affect the course of diabetic renal disease.[5] Although there are cases in which it appears that proliferative retinopathy accelerates during pregnancy, in most cases retinopathy is not adversely affected.

The major causes of neonatal mortality associated with diabetic pregnancies are congenital abnormalites and fetal death in utero. The incidence of respiratory distress syndrome due to immaturity of the fetal lungs has decreased now that amniocentesis with determination of the lecithin sphingomyelin (L/S ratio) is done before elective, preterm delivery. Cardiomyopathy may cause transient respiratory distress and is being recognized with increasing frequency. Other causes of morbidity in the infants of diabetic mothers include hyperbilirubinemia, hypoglycemia, and hypocalcemia.[6]

There is substantial evidence that complications of the diabetic pregnancy increase with rising maternal blood sugar levels. For example, the percent of infants who are large for gestational age is greater in women with hyperglycemia. These large babies often cannot be safely delivered vaginally and, thus, macrosomia is one factor responsible for the increased cesarean section rate in diabetic pregnancies. On the other hand when hyperglycemia is

controlled, the proportion of large for gestational age infants decreases. It is believed that most of the other complications also may be reduced or eliminated with normalization of the maternal blood sugar.[7]

Screening for gestational diabetes • Most patients with mild abnormalities in glucose tolerance are asymptomatic. Therefore, in many medical centers women who have factors such as a family history of diabetes, increased maternal age, or obesity which increase their risk of developing diabetes undergo a glucose tolerance test during pregnancy. However, a screening blood sugar obtained between 24 and 30 weeks of gestation is a more reliable predictor of abnormal glucose tolerance than any combination of risk factors.[8] If economic conditions preclude screening every woman, at least those over age 25 and those with several risk factors for diabetes should have a blood sugar drawn one hour after the oral ingestion of 50 gms of glucose (Table 1). If the screening blood sugar is greater than 150 mg/dl a three-hour oral glucose tolerance test performed after three days of liberal carbohydrate intake is needed to exclude or diagnose diabetes. Also a glucose tolerance test should be obtained on all women regardless of age if they have fasting glycosuria or a past history of gestational diabetes.

A 50 gram glucose solution is used in screening because it produces fewer gastrointestinal side effects than the 100 gram dose used in the standard glucose tolerance test. The glucose tolerance test should not be performed in those patients who are known to have diabetes or in those with a fasting blood sugar exceeding 105 mg/dl. The diagnosis of diabetes during pregnancy is established when two fasting blood sugar levels are greater than 105 mg/dl, or when two or more blood sugars obtained after a 100 gram oral glucose load are at least 190 mg/dl at one hour, 165 mg/dl at two hours or 145 mg/dl at three hours.

Table 1. — Detection and Diagnosis of Diabetes During Pregnancy.

Screen	Obtain a one hour blood sugar after a 50 gram oral glucose load on all patients except known diabetics between 24-30 weeks gestation.
GTT	Perform a GTT if the patient has any of the following: 1-hour glucose screen ≥ 150 mg/dl Fasting glycosuria Past history of gestational diabetes Past history of a stillborn
Diagnose diabetes	If on two days or more the fasting blood sugar is greater than or equal to 105 mg/dl or after a 100 gram oral glucose solution two or more blood sugars equal or exceed: 190 mg/dl at 1 hour 165 mg/dl at 2 hours 145 mg/dl at 3 hours

Classification • Until recently the most widely used classification of diabetes in pregnancy was based on the age the mother developed diabetes, duration of disease, and presence or absence of nephropathy, retinopathy or heart disease. In the past the timing of delivery was largely dependent on this classification system.

Now, early delivery even of patients with diabetes of long duration is frequently not advocated when blood sugar levels have been maintained within the normal limit throughout pregnancy. Therefore, the most useful classifications designate whether or not diabetes preceded pregnancy, pregestational or gestational diabetes mellitus, and whether there have been any complications associated with a previous pregnancy, the diabetes, or the current pregnancy. These are the factors which influence decisions now regarding the timing of delivery. For example, preterm delivery frequently is recommended in patients with the history of a previous stillbirth, in those with advanced retinopathy or nephropathy, and in those who are poorly controlled. Early delivery may not be recommended in well controlled diabetic women in whom no diabetic or obstetrical complications occur.

Diet • The goals of a diabetic diet during pregnancy are to provide good nutrition and minimize the frequency of hyperglycemia and hypoglycemia (Table 2). Weight loss and ketonuria are to be avoided as well as excessive weight gain. Frequent feedings, at least three meals and one or two snacks a day when taken on time, will minimize hypoglycemic reactions. Carbohydrates per se should not be restricted, but the foods which cause an excessive hyperglycemic response such as those containing large amounts of sugar should be avoided.

There should be more emphasis on proper timing and balance of meals than specific foods. Rather than preset proportions of carbohydrates, proteins, and fats and predetermined calorie levels based only on the patient's height and/or weight, diets devised with consideration of each patient's food preferences and activity schedule should be recommended. A dietician is invaluable for planning individualized diets and instructing patients in the basic principles of nutrition.

The caloric intake should be liberal enough to ensure a steady weight gain. Specifically, pregnancy is not the time for overweight women, even those who are diabetic, to diet and lose weight. A weight gain of 12½ kilograms is recommended for women of normal weight at the onset of pregnancy. Those who are overweight at the beginning of gestation need not

Table 2. — Management of Hyperglycemia During Pregnancy

Diet

Institute dietary therapy when diabetes is diagnosed.

Dietary recommendations include:

Three well-balanced meals with one to three snacks daily
Adequate calories to insure adequate weight gain.
Limitation of sugar to facilitate tight control of the blood sugar.
Consistent timing and content of meals and snacks from day to day.
Extra snacks or meal portions on days when there is an increased amount of exercise.

Insulin

Initiate treatment when the fasting serum sugar is greater than 105 mg/dl or two hour postprandial sugar is greater than 120 mg/dl.

Start with 0.5 units/kg. of body weight once daily.

Adjust the insulin dose to acheive a fasting blood sugar of 60 to 90 mg/dl and two hour postprandial glucose levels of 80 to 120 mg/dl.

If normal glycemia throughout the 24 hour period is not achieved with one dose of insulin, divide the dose and give two or more injections per day.

For an elevated fasting blood sugar, start or increase the NPH or Lente insulin given in the p.m.

For elevated postprandial blood sugars, increase the NPH or Lente insulin before breakfast or increase regular insulin given before that particular meal.

Expect the insulin dose at term to be about one unit/kg body wieght or more.

gain this much weight as long as ketonuria does not develop. The best signs of an adequate caloric intake is the absence of ketonuria and a steady weight gain.

The foods that should be avoided by diabetics during pregnancy are those which are noted to cause postprandial hyperglycemia. These foods may be identified when blood sugar is frequently monitored. Dietary recommendations for both diabetic and pregnant patients have changed during the past few years and many questions regarding nutritional management of the pregnant diabetic remain unanswered.[9] Basically there is very little difference between the diet advocated for diabetic women and nondiabetic women during pregnancy.

Insulin therapy • Insulin therapy is usually instituted if the fasting blood sugar is above 105 mg/dl on two or more occasions or if the two-hour postprandial blood sugar is above 120 mg/dl after the patient has been on a diet which eliminates foods high in sugar content (Table 2). The aim of therapy is to keep the fasting blood sugar in the range of 60-90 mg/dl and the two-hour postprandial blood sugar between 80 and 120 mg/dl. Early in pregnancy 0.5 to 0.7 units of insulin per kilogram body weight may be adequate to maintain normoglycemia, whereas at the end of pregnancy most patients will require a dose of one unit or more per kilogram body weight.

If postprandial blood sugars are normal and the fasting blood sugar remains elevated on dietary therapy alone, NPH or Lente insulin should be started at bedtime. On the other hand, if the fasting blood sugar is normal and only the postprandial glucose levels are elevated, NPH or Lente insulin is given before breakfast. Regular insulin is added to this if the blood sugar after breakfast continues to be greater than 120 mg/dl. If the blood sugar is controlled for only part of each day on one injection, the insulin dose is split and given twice or more daily. The most frequent schedule for insulin administration is Lente or NPH plus regular insulin in the morning before breakfast with the combination of the same insulin types before supper. If the blood sugar remains elevated after lunch or before breakfast on two doses of insulin a day, a third shot may be necessary. Occasionally even four doses of insulin may be used to insure the best possible control and the most flexibility in timing of meals.

Initially when the insulin dose is given twice a day, two thirds may be given before breakfast and one third before supper. The baseline insulin dose may be increased or decreased by 10% every three days when there is a consistent pattern of high and low blood sugar levels at a particular time of day.

In general, when NPH and regular insulin are used twice a day before breakfast and before supper, the dose of regular insulin may be increased before breakfast to prevent recurring hyperglycemia during the late morning and early afternoon. Additional NPH may be needed to prevent hyperglycemia in the late afternoon and early evening. Additional regular before supper may be added to control high blood sugars after the dinner meal at night, and an increase in the NPH dose given before supper may be needed to prevent fasting hyperglycemia.

The number of blood sugar determinations needed for proper management must be individualized. Obviously the intervals between glucose determinations can be longer when all blood sugar levels are normal, and much more frequent testing is necessary when the blood sugars are variable or out of control. Ketonuria with hyperglycemia usually requires hospitalization and an immediate alteration of the insulin dose. Most patients will need to check their blood sugar four to seven times daily to attain the best possible control. However, if all glucose

levels are normal, patients who take insulin may reduce the frequency of testing to two to four times daily and those who are diet controlled may test twice weekly.[10,11] Ketonuria without hyperglycemia is an indicator that the caloric intake should be increased. A larger snack at bedtime may be required to prevent early morning ketonuria.

When there is general agreement that stringent control to avoid hyperglycemia is a desirable goal in pregnant diabetic patients, the potential hazards of maternal hypoglycemia have been largely ignored. With increasing emphasis on tight control, nocturnal hypoglycemia has become more common. Patients who have frequent reactions during the night may benefit from a "Sleep Sentry," a device the size of a watch which will beep when sweating or a drop in skin temperature occurs. These signs although nonspecific frequently accompany hypoglycemia. When nocturnal hypoglycemia is recurrent, the NPH insulin dose given in the afternoon should be decreased. If the hypoglycemic reactions persist or fasting hyperglycemia begins to occur, the intermediate acting insulin dose should be given at bedtime rather than before supper.

No matter how diligently patients follow recommendations regarding diet and insulin therapy and how carefully a program is outlined for them, some patients will achieve control more easily than others. The degree of blood sugar control depends not only on the therapeutic program recommended and the willingness of the patient to adhere to the recommendations but also on the type of diabetes the patient has and the trimester of pregnancy. Type I diabetic women who have large fluctuations in blood sugar prior to onset of pregnancy will have much more difficulty achieving tight control during the first trimester than later in gestation. Both type I and type II diabetics will note an increasing insulin need as pregnancy advances but type II patients will have less variability in the daily swings in blood sugar.

At the time of delivery, insulin need decreases dramatically. The usual dose of insulin may be given the day before elective induction of labor or cesarean section. The day of delivery, IV glucose and regular insulin are titrated to insure adequate caloric intake and normoglycemia. Again frequent blood sugar monitoring will be necessary to maintain the proper balance between insulin delivery and the quantity of glucose given. For a starting point, 20 units of regular insulin may be placed in 1,000 cc of 5% glucose and infused at a rate of 150 cc per hour. Additional glucose or insulin may be needed depending on subsequent blood sugar levels.

In insulin dependent diabetics, approximately two thirds of the insulin dose that the patient was on prior to pregnancy may be given the day after delivery with extra regular insulin added if hyperglycemia occurs. Generally, insulin is not given postpartum to patients with gestational diabetes unless blood sugar levels exceed 200 mg/dl.

Insulin antibodies • All patients treated with insulin will develop antibodies to the insulin with time. Although there is no direct evidence linking complications of pregnancy to antibody levels, it is known that repeated exposure to beef insulin may cause significant rises in antibody levels. Therefore, pork or human insulin should be used in gestational diabetic patients who may need the drug only temporarily. In women with insulin treated pregestational diabetes, consideration also should be given to the possibility of using human insulin for several months or more prior to pregnancy to ensure the lowest possible antibody levels.

Home glucose monitoring • During pregnancy the renal threshold for glucose decreases dramatically resulting in glycosuria with blood sugar levels as low as 100 mg/dl. In fact, about 25% of all women will demonstrate glycosuria at some time during their pregnancy. Although urine sugars do correlate with blood glucose levels, the change in the renal threshold as well as the need to very tightly control the blood sugar during pregnancy has outmoded the use of urine glucose levels to regulate pregnant diabetics. Instead, frequent blood sugars determined by the patient at home have become the standard.[12]

Reagent strips are available which can be read visually to within 20% of the blood sugar level obtained in the laboratory. With the use of a reflectance meter, accuracy can be increased further. Blood sugars cannot practically be obtained in the laboratory multiple times per day on a long term basis, making home glucose monitoring the only practical means for regulating insulin doses during pregnancy.

There may be several possible pitfalls with home glucose monitoring. For example, the reagent strips when old or exposed to moisture may become inaccurate; readings then may be on the low side. In fact, the expiration date on the bottle actually applies only if the bottle is unopened. Special care must be given to tightly closing the bottle after each use. Secondly, if a large amount of blood is not placed on the strip or if the strip is vigorously rinsed or blotted the reading will be too low. Inaccurate timing frequently will cause erroneous results as well. To insure that the proper technique has been mastered several values obtained by the patient should be checked against serum glucose values determined in a certified laboratory. When there is a greater than 15% variation between the patient's and the laboratory values, more instruction in home glucose monitoring is recommended. Control samples and repeat determinations in the laboratory done at intervals are necessary to insure continued accuracy with the home glucose tests.

Reagent strips now cost about 50 cents each. If they are read visually, the strip may be cut longitudinally so that two tests may be obtained for every strip, but the whole strip must be used in the reflectance meters. Different reflectance meters are available for use with each specific reagent strip; most meters are quite reliable when the proper procedure is followed. Each machine has some advantages and disadvantages, and it is helpful if patients are able to watch a demonstration of two or more of the instruments so they may decide which one they would be most comfortable using at home. Most third party carriers will cover at least part of the cost of the meters which average $150 or so.

Antenatal fetal assessment • The most commonly used procedures to evaluate the fetus in utero are ultrasonography, nonstress tests (NST), contraction stress test (CST), and amniocentesis (Table 3). Determination of the fetal biparietal diameter at 18 weeks gestation is helpful in accurately establishing gestational age. Nonstress tests are done weekly after the 34th gestational week and are considered to be reactive when the fetal heart rate increases by at least 15 beats per minute following fetal movement. If the nonstress test is nonreactive (no increase in the fetal heart rate with movement), a CST is done. No change or an increase in the heart rate following uterine contractions induced by oxytocin or nipple stimulation is reassuring. Early delivery should be strongly considered if late deceleration of the heart rates follows uterine contractions.

Urinary estriol determinations were once widely used to assess the fetal/maternal unit but are rarely used now.[13] Maternal urine and serum estriol levels normally increase progressively with advancing gestation. A fall in the serum urine estriol of greater than 35% compared to the mean of the previous three days usually is indicative of fetal distress.

Table 3 – Antenatal Fetal Assessment.

Ultrasonography is done between 16-30 weeks of gestation to estimate gestational age.

Beginning at 34 weeks gestation, nonstress tests are conducted weekly. If there is a history of previous stillbirth, the test is done biweekly.

A contraction stress test is done if the nonstress test is nonreactive.

Serum or urinary estriol levels are not frequently done; centers that use the test obtain these daily especially in patients with a nonreactive nonstress test or a suspicious contraction stress test, or as the clinical situation dictates.

Impending intrauterine death cannot always be predicted by any of these tests; however, when the NST and OCT are not reassuring early delivery should be considered.

The incidence of prematurity and respiratory distress syndrome has been markedly reduced by the routine use of amniocentesis to determine fetal lung maturity before elective delivery. The respiratory distress syndrome, secondary to hyaline membrane disease, is charactreized by collapse of the lungs upon exhalation due to the lack of alveolar stability. The collapse of the alveoli results from deficiency of surface active phospholipids, one of which is lecithin. Amniotic fluid lecithin concentrations rise throughout gestation with an abrupt increase occurring at 35-36 weeks. A L/S ratio of greater than 3/1 is associated with fetal lung maturity and a low incidence of hyaline membrane disease.[14]

Although some skeletal abnormalities such as spinal agenesis may be noted on ultrasonography, there is no accurate way to exclude the presence of most congenital abnormalities prior to delivery. The evidence that poor diabetic control is associated with an increased incidence of major congenital anomalies[15] has prompted us to advise all diabetic women to postpone pregnancy until glycosylated hemoglobin levels are normal. We support the belief that the best way to reduce the incidence of abnormalities is to maintain as good control as possible at the time of conception and in the early weeks of gestation.[16]

Genetic factors • It has become increasingly apparent that diabetes mellitus is not a single disease but rather a number of diseases in which blood sugar elevation is a principle feature. At least two types of diabetes are now recognized: type I and type II. Type I insulin dependent, ketosis prone diabetes mellitus usually develops before age 35. This type was previously classified as juvenile onset diabetes, and is characterized by lability of the blood sugar. Type I diabetes mellitus does not appear to be directly inherited but susceptibility to the disease is geneticaly transmitted. Type I diabetes often is associated with certain human leukocytes antigens (HLA). These antigen sites on the sixth chromosome may be markers for genes that are responsible for the increased susceptibility to ketosis prone diabetes. There is no close association, however, between the HLA types and maturity onset or type II diabetes. Type II diabetes on the other hand is very likely an inherited metabolic disorder in which environmental factors may play a role. Obesity, for example, may precipitate the disease.

Overall, the child of a diabetic parent has between a 2-6% chance of developing diabetes before age 25 or about a 10% chance of having diabetes by age 65. The increased risk is primarily for the same type of diabetes (type I or type II) that the parent has.

Patient education • Most diabetic patients will have many questions regarding management of diabetes as well as the risks of pregnancy. A fact sheet answering these questions or a pamphlet containing information about diabetes in pregnancy may help to reduce anxiety and enhance compliance. During pregnancy most patients are highly motivated and receptive to changes in diet as well as to home monitoring of blood sugar. With frequent blood sugar determinations and careful attention to details of management during pregnancy, it becomes obvious to patients that good control can be achieved. This may be helpful in motivating patients to assume more responsibility for their own control not only during pregnancy but after delivery as well.

Certainly the role of a team consisting of a perinatologist, dietician, diabetes educator, pediatrician, in addition to the patient's internist or family practitioner, is to be supportive and to insist repeatedly that blood glucose control can be achieved. Now that there is evidence that the incidence of congenital abnormalities varies with the degree of control, all young diabetic women should be advised regarding the need for very strict tight control of their blood sugar prior to conception. In addition they should be counselled regarding the expense and time involved in the usual therapeutic program that must be followed during pregnancy. Women with diabetes who understand the risk involved, especially to the infant, should not be discouraged from becoming pregnant. Instead, every effort should be made to provide optimal medical care to insure the best possible outcome of the pregnancy.

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Pseudocarcinoma: a major pitfall in the practice of hematology/oncology

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ABSTRACT: In any area of medicine, correct therapy of a disease depends upon accurate diagnosis. In hematology-oncology, additional burdens of a false diagnosis of cancer include emotional issues and the real threat of therapeutic side effects of nonindicated chemotherapy. The patient with an established diagnosis of cancer, particularly if in a stable situation, is not protected from other maladies unrelated to the malignancy. Therefore, new signs and symptoms of disease are not necessarily those of cancer progression. Using examples from an active teaching hospital practice, some points are made which are hopefully instructional.

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Imparting a diagnosis of cancer leaves a patient not only with the perception of the bad news of a disease usually having a poor prognosis but also raises fears, some justified and others not, of chemotherapy, the real likelihood of "patient abandonment" by nursing and other supporting personnel, and the concern by family members of contagiousness of cancer. As foreboding as these may be, perhaps even more tragic are these feelings in the face of either a false diagnosis of cancer or a major complication of cancer in an otherwise stable patient. I will call these clinical situations "pseudocarcinoma." By way of example using several cases in my teaching hospital practice, I will attempt to illustrate either the false diagnosis of cancer or, in a stable patient with cancer, a side effect or an unrelated illness ascribed to a relapse or acceleration of the primary disease.

The problems with a false diagnosis of cancer or a related event are enumerated in Table 1. I have already mentioned patient abandonment which is too often a real event. Frequently, we have seen staff enamored by the diagnostic pursuit of a fever of unknown origin only become dismayed and often neglect the patient if that fever proves to be due to occult carcinoma. Too often I have seen the attitudes of nursing and paramedical personnel dramatically change as soon as a diagnosis of cancer is made. If a diagnosis is indeed falsely made, the disease process accounting for the signs and symptoms is either not treated or treated in a delayed fashion after further progression. The majority of diseases mimicking cancer are readily treatable and include tuberculosis, lupus erythematosus, and others. Chemotherapy may have been administered for an underlying nonmalignant disease. Not only do diseases such as tuberculosis not respond to cancer chemotherapy but, additionally, all the side effects are needlessly

encountered and perhaps the primary disease is even aggravated by chemotherapy, such as prednisone being administered to someone actually having tuberculosis. Naturally, all this results in not only incorrect care of the patient but perhaps a medical-legal difficulty. Lastly, whenever the truth is discovered, either by another physician or in the autopsy suite, professional embarrassment results.

It is our opinion that these pitfalls should be expressed not to enhance embarrassment but to make persons aware that such mistakes are possible and to use these misadventures as teaching points.

Report of cases — **Case 1.** — At 34 years of age, this patient presented with a massive burden of tumor which was proven to be disseminated anaplastic seminoma. Because of the tremendous bulk of disease, he was treated aggressively with concurrent chemotherapy and radiotherapy. He had a dramatic remission with resolution of all observable tumor. However, beginning approximately a month after remission and over the following year, he mysteriously lost approximately 100 pounds. He then appeared quite emaciated, showing all the clinical, physical, and laboratory signs of severe malnutrition. The admitting diagnosis was relapse of the tumor. He had no specific complaints and physical examination only showed the emaciated man. Radiographs and computed tomographic studies did not disclose any residual tumor. In spite of denial of dysphagia, it was noted by the housestaff that attempts to eat were obviously extremely difficult for the patient who confided that he thought that this was only natural following chemotherapy and radiotherapy. A barium swallow of the esophagus showed extreme stenosis of nearly the entire esophagus. In retrospect, he had severe erosive esophagitis concomitant with the combined chemotherapy and radiotherapy. Appropriate dilatation therapy of his esophagus resulted in a dramatic response. The patient has regained 100 pounds and now, five years later, remains in total remission and is of normal weight.

Extreme weight loss, emaciation and negative nitrogen balance made the housestaff quite convinced that this patient had a recurrence of his tumor although it was not to be found. Only through close clinical observation was it determined that the man did in fact suffer from severe dysphagia. The ease with which a diagnosis can be confirmed following proper suspicion does not negate the fact that a diagnosis is still easy to miss. It must be thought of first. It also points out that relatively simple treatment, bouginage, was more therapeutic and more easily administered and accepted than another cycle of aggressive chemotherapy.

Table 1. — Problems Related to False Diagnosis of Cancer.

Patient abandonment
No therapy for the underlying disease
No indication for administered chemotherapy
"Pain and suffering"
Professional embarrassment

Case 2. — At age 60, this woman presented with fairly classic nodular poorly differentiated lymphoma and was appropriately treated with combination chemotherapy using cyclophosphamide, vincristine, and prednisone achieving a gratifying response. Over the next year, she complained of lethargy and weakness and was found on physical examination to have large pleural and pericardial effusions. In spite of search for tumor mass, conversion to a more aggressive form of lymphoma, or even leukemic involvement of her disease, no evidence for such was found. She continued to become weaker and more lethargic. When her primary care hematologist-oncologist was out of town, the patient was attended in the outpatient clinic by another physician. The patient was diagnosed as suffering from myxedema which was confirmed by laboratory testing. More importantly, administration of thyroid hormone resulted in prompt resolution of all symptoms and abnormal laboratory and clinical findings.

Things are not always what they seem. This woman was assumed to have a recurrence of her tumor and perhaps even obstruction of her thoracic duct by tumor because of the weakness, lethargy and accumulation of pleural fluid. There is an association between autoimmune diseases such as hypothyroidism and lymphoma. Only after several months, when the myxedema became quite pronounced, was the insidious but pernicious development of this endocrinopathy noted at first glance by another physician. For this reason alone, perhaps it is good that several physicians attend the mixture of complex patients such as these.

Case 3. — This 65-year-old woman had been suffering from pancytopenia for the last four years. At that time she was found to have a nonspecific hyperplastic myeloproliferative disorder. Unfortunately, her hematocrit was low so that for the next four years she had to be supported by transfusions at the rate of approximately three units of packed red cells every month. She began to complain of more weakness and tiredness; the transfusion pace was accelerated. However, attempts to keep her hematocrit as high as even 30% did not alleviate her symptoms. Attempts to document conversion of her vague myeloproliferative disorder to frank leukemia were unsuccessful. Again, it was only when seen by a new disinterested party, namely the emergency room housestaff, was it appreciated this woman was in chronic diabetic ketoacidosis. Her blood glucose levels were in the range of 600-700 mg%. She had heavy glycosuria and mild ketonuria. Subsequent evaluation showed, in fact, she had developed hemochromatosis most likely related to her transfusion burden and that she was now suffering from the endocrinopathy of that disorder. She responded fairly well to insulin therapy.

Again, the insidiousness of the side effects of her treatment (in this case transfusion) made it difficult to appreciate the fact that she was manifesting a different disease. The "therapeutic blinders" of her primary physician restricted the diagnostic possibilities to only those involving the myeloproliferative disorder or leukemia.

Case 4. — This 50-year-old man had undergone colon resection three years previously for adenocarcinoma which proved to be Duke's classification C. He intermittently returned to the surgical clinic for follow-up. For the last several months, he had been complaining of increased weakness but no weight loss. It was found that his calcium was 15 mg/dl. On chest x-ray, he had approximately 20 nodular densities in each lung field. He was diagnosed as having widely metastatic carcinoma of the colon with hypercalcemia and was transferred to the medical service. A workup there showed no evidence of liver metastases. More importantly, the chest x-rays from the hospitalization at which time his colectomy was performed were reviewed and showed exactly the same number and size of densities as the present x-ray. Apparently these had not been appreciated at the time of colectomy. After having his calcium controlled by saline diuresis, he underwent a thoracotomy which proved him to have sarcoidosis. He has responded well to therapy for that disorder and has not had recurrence of the carcinoma.

It would be distinctly unusual to have this many lung metastases from colon cancer without first having involvement in the liver. A review of the previous medical record, which seems to be often forgotten in modern day medicine, showed that his current chest x-ray was essentially unchanged. Hypercalcemia would be unusual in metastatic colon carcinoma but quite typical of sarcoidosis. Had the correct diagnosis not been appreciated, he would have expired from hypercalcemia. If so, and had an autopsy not been performed, the misdiagnosis would have been a self-fulfilled prophesy.

Case 5. — This middle aged nurse presented to the hospital because of weight loss, chills and fevers. She was found to have a hematocrit of 28% and a chest x-ray showing multiple nodules in each lung field. Her family history was positive for carcinoma of the breast. She had a moderate pericardial effusion. Pericardiocentesis revealed bloody fluid which was negative for tumor cells. She was diagnosed as having carcinomatosis with pericardial involvement with breast as the probable primary site. Examination and mammography failed to reveal any masses. No tumor could be found. At that point, a repeat detailed history and physical without emphasis on carcinoma were done. New findings included cytoid bodies in the eye grounds and a sedimentation rate of 130 mm/hr. Percutaneous biopsy of one of the lung nodules revealed granulomatous tissue. She was then diagnosed as having Wegener's granulomatosis. She had a prompt and dramatic lasting remission induced by prednisone administration.

Early in her evaluation, this woman was diagnosed as having carcinoma which was proven to be wrong. Whereas sedimentation rates are commonly increased in carcinomatosis, in this case the elevation was excessive. The finding of cytoid bodies was more consistent with a rheumatic phenomenon. Biopsy proved that she had a granulomas disease rather than a milignant disease.

Case 6. — An elderly black man was admitted to the hospital for fever, weight loss and jaundice. Examination showed a large ill-defined epigastiric mass. Laboratory examination showed an increase in his plasma direct bilirubin and alkaline phosphatase. He was diagnosed as having carcinoma, most likely of pancreatic origin. The man steadfastly refused laparotomy and within a month or so expired. Autopsy showed tuberculous peritonitis with a large omental mass.

This man unfortunately died of what was probably a treatable disorder. His lack of cooperation no doubt assisted in the misdiagnosis; however, had other diagnoses been seriously entertained, perhaps more force could have been brought to bear for a diagnostic procedure.

Case 7. — A 70-year-old man came to the hospital with extreme fatigue complaining of having last been well approximately a year ago. During that time he had lost 100 pounds. Physical examination was unremarkable at the time except for weight loss. A radiographic search for cancer was unrevealing although everyone was convinced he had cancer. When roentgenography failed, the history and physical were again repeated with attention to the possibility of nonmalignant diseases in mind. It was discovered that he had mild diarrhea but not enough to account alone for the weight loss. It was also noted on reviewing his graphics that he had exhibited nocturnal tachycardia at a time he did not have fever. Thyroid studies were obtained and it became clear at once that he was suffering from apathetic hyperthyroidism.

Even in retrospect, this man did not have any of the classical signs of hyperthyroidism but rather had an enormous amount of weight loss and presented with otherwise nonspecific findings. Appropriate follow-up of one small clue, namely tachycardia, resulted in the appropriate diagnosis. He responded dramatically to treatment and has regained the vast majority of his weight and strength.

Case 8. — A 75-year-old man presented to the hospital because of "falling down spells." He also had mild dementia and evaluation showed frontal lobe dysfunction and papilledema. Computed tomographic studies of the head showed a large frontal mass but also two or three smaller masses in the cerebellar area. He was diagnosed as having a primary brain tumor, most likely glioblastoma multiforme. Neurosurgical consultation did not think that biopsy was warranted. He was given radiation, 4,000 R, with improvement in his signs and symptoms. He died a month or so later from a downhill course with progressive frontal lobe dysfunction. Autopsy showed multiple cryptococcal abscesses of the brain.

This patient was misdiagnosed but according to all observers got some temporary relief from radiotherapy. A clue was that a large brain tumor should not have multiple satellite lesions which classic cryptococcal disease may demonstrate. In retrospect, the patient had been administered a brief but intense course of prednisone for Bell's palsy several months before his symptoms began which may have activated previous cryptococcal disease with secondary hematogenous spread. This patient was treated without a tissue diagnosis.

Case 9. — This middle-aged man had a mediastinal presentation of Hodgkin's disease, mixed cellularity type. He was treated with aggressive radiotherapy to the chest and multiagent chemotherapy with a dramatic response. He had resolution of all the tumor mass for approximately four years after which time he presented to the clinic complaining of lethargy and weakness. His wife pointed out that his face had become puffy. He was diagnosed as having a probable recurrence of mediastinal Hodgkin's disease with superior vena caval compression. Appropriate studies failed to confirm that diagnosis. When we recognized what ports were used for his radiotherapy, thyroid studies were obtained which showed a marked degree of hypothyroidism. His lethargy, weakness, and puffy face all responded promptly to thyroid replacement and he is still in clinical remission from both Hodgkin's disease and myxedema.

Obviously one of the side effects of radiotherapy to the neck can be hypothyroidism. This is usually a long-term side effect. This may not be appreciated in patients who do not as a rule survive long enough to develop this complication.

Discussion • Table 2 represents some diseases which can mimic carcinomatosis and all of which I have observed. Obviously, every disease needs to be confirmed before a sound diagnosis can be made. The practice of clinical medicine makes it clear that not everyone can have a firm diagnosis every time but one should attempt to minimize misdiagnoses. The primary mechanism for doing such is certainly the "golden rule of hematology-oncology" which is to get a tissue diagnosis. As the diagnosis of cancer will more often be correct than incorrect in cases such as we have presented, sometimes one feels reluctant to confirm "the obvious," particularly when appropriate confirmation of the diagnosis may involve time, expense, and pain. Surgical colleagues may be reluctant to perform biopsies for what at first glance would seem obvious. However, it is cases such as these that underscore the real necessity of a tissue diagnosis.

The diseases listed in Table 2 are in general much more pleasing to treat than carcinoma or a complication of cancer had the tumor previously been in remission. Of the nine cases reported, the majority had comparably treatable diseases which were rather gratifying to the clinician and to the patient. Perhaps all would agree that it is more efficacious to look for readily treatable disease (even if this necessitates tissue diagnosis or other confirmatory methods) in the bulk of patients who appear to have cancer than to miss such cases. In my estimation the overall morbidity and mortality of these diagnostic procedures are clearly justified.

Table 3 lists the primary paths by way of which one can find himself in a diagnostic pitfall in hematology-oncology. As mentioned, the first principle of getting a tissue diagnosis is usually violated. Failure of appreciating the natural history of a patient with a known cancer often gets one involved as the

Table 2. — Diseases Which May Mimic Carcinomatosis.

Tuberculosis
Syphilis
Whipple's disease
AIDS
Giant cell arteritis
Wegener's granulomatosis
Lupus erythematous
Thyroid disease
Addison's disease
Sarcoidosis
Amyloidosis
Poisoning
Malabsorption
Starvation

Table 3. — Paths Leading to Pitfalls

Failure to get tissue diagnosis
Failure to appreciate natural history of a malignancy
Failure to appreciate side effects of therapy
Diagnostic blinders may give diagnostic blunders
Assume too much

failure to realize that liver metastases are most common in patients with colon cancer as represented in Case 4, or failure to realize the association of autoimmune diseases such as the patient in Case 2 who developed hypothyroidism as almost a natural consequence of the underlying lymphomatous process. There are long term effects of chemotherapy such as illustrated by the patient in Case 1 who had the severe esophageal stricture and the patient in Case 9 who developed hypothyroidism following radiotherapy four years previously. Certainly the modern practice of any subspeciality consciously or unconsciously leads one to employ therapeutic blinders. We diagnose what we see and we see what we know. However, as these cases demonstrate, one may not always "see" with clear vision. Finally, it is too easy to assume things. One certainly recalls what one needs to add to "U" and "Me" to equal "assume."

Acknowledgment

The author recognizes the secretarial excellence of Dellia H. Burchette in the preparation of this manuscript.

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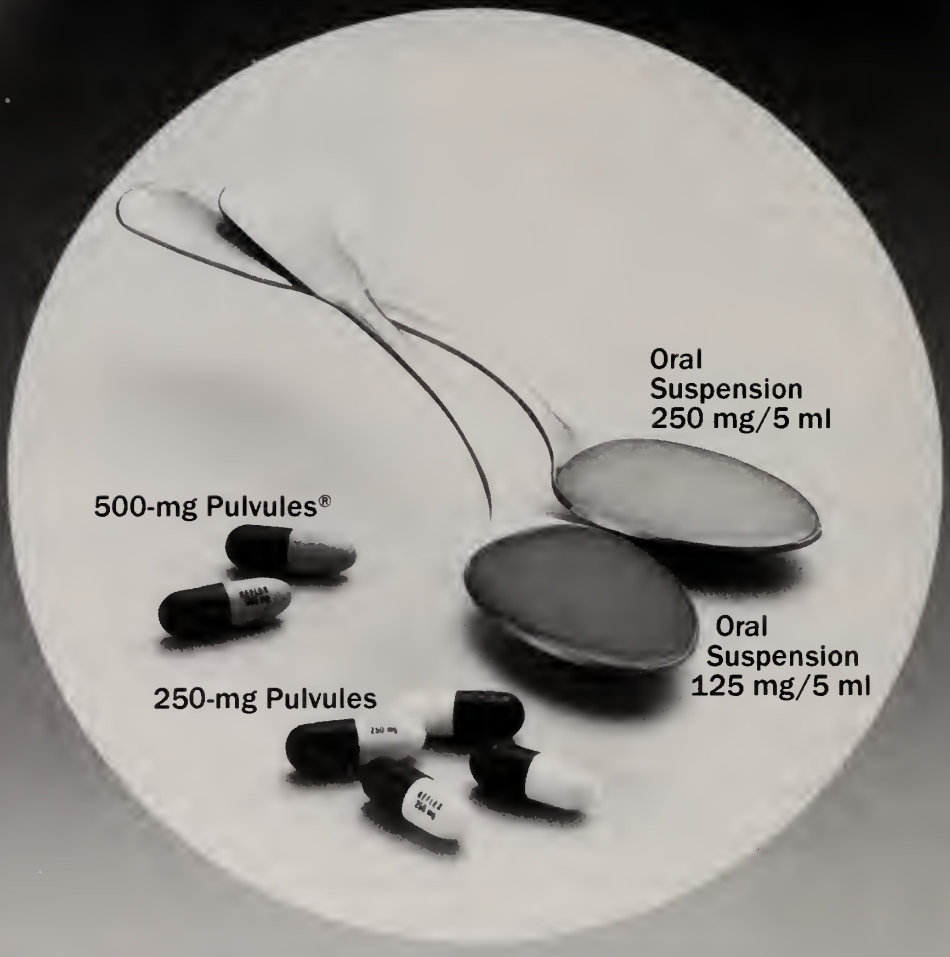
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SPECIAL ARTICLE

The Florida Patient's Compensation Fund and the Florida Medical Malpractice Joint Underwriting Association

William M. Howard, Ph.D.

The Florida Patient's Compensation Fund, established by statute in 1975 to provide malpractice insurance for Florida doctors and hospitals, has incurred substantial deficits. Doctors who were members of the Fund have been assessed $24 million in addition to the fees (or premiums) they have paid and hospitals have been assessed an additional $143 million. Doctors cannot be assessed further according to the statute under which the Fund was established though there is some doubt on this point. Estimates of additional assessments that may be levied against hospitals for fiscal years 1976-77 through 1981-82 range from about $150 million to more than $400 million.

No doctors have been members of the Fund since June 30, 1983. No hospitals have been members since June 30, 1982.

The Florida Patient's Compensation Fund appears to have served several thousand Florida doctors with reasonable success for the period July 1, 1976 through June 30, 1983. It appears to have shifted a substantial part of the cost of malpractice insurance from participating doctors to participating hospitals. For participating hospitals, operation of the Fund may fairly be characterized as a misfortune if not a disaster.

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The Florida Medical Malpractice Joint Underwriting Association, established by Florida Statute in 1975 to assure the availability of the underlying limits of malpractice insurance required of doctors as a condition for participating in the Fund, appears to have operated successfully.

Establishment of the Fund and the Association • In 1975 the State of Florida established two agencies intended to relieve problems related to professional liability: The Florida Patient's Compensation Fund and Florida Medical Malpractice Underwriting Association. The need resulted from rapidly rising premiums for malpractice insurance and the decision of major insurers to greatly reduce the amounts of malpractice insurance written in Florida. Malpractice insurance threatened to become virtually unavailable to many Florida doctors and hospitals.

The Florida Patient's Compensation Fund was established as an assessable compensation fund to provide for payments to patients who make claims against doctors, osteopaths, podiatrists, and hospitals,[1] and for defense of such claims. For the fiscal year 1976-77 and there-after coverage was also provided for health maintenance organizations, ambulatory surgical centers, and professional associations. The coverage is similar to insurance though the Fund is not an insurance company. The statute provided for a limitation of doctors' liability over $100,000 per claim and $500,000 per occurance and provided that claimants must name the Fund as a defendant for any amounts claimed in excess of the underlying limits. To participate in the Fund doctors were required to provide for payments of at least $100,000 per claim and an aggregate limit of $500,000 per occurrence through insurance, self insurance, or other means specified by statute as a condition of

membership. Thus, a doctor who joined the Fund was fully protected against loss arising from malpractice lawsuits.

The Florida Medical Malpractice Joint Underwriting Association was created to provide the $100,000/$500,000 underlying limits of insurance required for participation in the Fund. Doctors and other providers who obtained medical malpractice insurance through the Association were not required to be members of the Fund and members of the Fund were not required to be members of the Association.

Contributions to the Fund were set at $1,000 for doctors for the fiscal year 1975-76 and renewal contributions were set at $500. First year contributions for hospitals were $500 per bed and renewal contributions $300. Those rates remained in effect through the 1979-80 fiscal year. Rates for doctors for various years are shown in Table 1. Rates for other providers are shown in Table 2.

Any deficits to the fund for any fiscal year were to be recovered by assessment of those who were members in that year. The assessments were originally limited for doctors to a maximum of an amount equal to the original membership fee for that year. They were subsequently increased to 200% of the original membership fee for 1982-83 and were increased to the amount required to pay losses and expenses for 1983-84 — that is possible assessments were unlimited. No doctors were members of the Fund for the 1983-84 fiscal year and none have become members since then. There is no limit to the assessment for other providers.

Financial experience of the Fund • Deficits have, in fact, occurred. The Insurance Commissioner has issued seven orders of assessment, each providing for one or more fiscal years.

Date of Order or Notice	Fiscal Year
September 22, 1982	1976-77
January 13, 1982	1977-78
July 28, 1982	1977-78 and 1978-79
September 11, 1982	1979-80
March 14, 1983	1980-81
September 19, 1983	1976-77, 1977-78, 1978-79, 1979-80 and 1980-81
November 9, 1984	1977-78, 1979-80, 1980-81 and 1981-82

These assessments are summarized in Tables 3 and 4. The sum of the assessments is $170 million.

Table 1. — Rates for Individual Doctors by Class and Fiscal Year.*

	Class 1		Class 2		Class 3		Class 4		Class 5	
	1st Year	Renewal	1st Year	Renewal	1st Year	Renewal	1st Year	Renewal	1st Year	Renewal
Territory 1**										
1975-76	$1,000		$1,000		$ 1,000					
1976-77	1,000	$500	1,000	$500	1,000	$ 500				
1977-78	1,000	$500	1,000	500	1,000	500				
1978-79	1,000	500	1,000	500	1,000	500				
1979-80	1,000	500	1,250	750	1,500	1,000				
1980-81	1,125	625	1,438	771	1,175	1,250				
1981-82	852		1,534		4,323					
1982-83	2,380		5,408		11,074		$16,319		$19,816	
1983-84	1,919		4,361		9,287		13,687		16,621	
Territory 2***										
1979-80	$ 912	$412	$1,117	$617	$ 1,323	$ 823				
1980-81	1,015	515	1,271	771	1,529	1,029				
1981-82	698		1,257		3,543					
1982-83	1,428		3,245		6,644		$ 7,971		$11,890	
1983-84	1,151		2,617		5,573		8,212		9,975	
Territory 3****										
1982-83	$ 952		$2,163		$ 4,429		$ 6,528		$ 7,926	
1983-84	768		1,744		3,715		5,475		6,648	

*Doctors with $100,000 underlying coverage for fiscal years 1975-68 through 1981-82; $150,000 underlying limits for 1983-84.

**All of Florida to June 30, 1979; Dade and Broward Counties thereafter.

***All of Florida except Dade and Broward Counties, July 1, 1979 to June 30, 1982; Palm Beach, Pinellas, Duval, Hillsborough and Orange Counties thereafter.

****All of Florida except Territory 1 and Territory 2 after July 1, 1982.

Source: Florida Patient's Compensation Fund Rate Schedules for various years.

Table 2. — Fees Paid by Individual Hospitals, Health Maintenance Organizations and Ambulatory Surgical Centers in Various Years.

	Hospitals (per bed)	Health Maintenance Organizations (per 100 subscribers)	Ambulatory Surgical Centers (per 100 out patient visits)
1976-76	$300	$200	$30
1976-77	300	200	30
1977-78	300	200	30
1978-79	300	200	30
1979-80	300	200	30
1981-82	310	200	30
1982-83	710*	200	30
1983-84	820**	200	30

*Dade and Broward Counties.

**Dade and Broward Counties, $150,000 primary insurance limits, $5,000,000 Florida Patient's Compensation Fund limit, including the primary limit, through the Fund.

Source: Florida Patient's Compensation Fund Rate Schedules for various years.

Doctors	$ 24,101,510
Hospitals	143,197,243
Health Maintenance Organizations, Ambulatory Surgical Centers and Professional Associations	$ 2,900,013
Total	$170,198,766

Doctors who have been members of the Fund have been assessed maximum allowable assessment for each year through 1981-82. Assessments of hospitals, ambulatory surgical centers and health maintenance organizations have been much more than the original membership fees. For the years 1979-80 and 1980-81 each of these providers have been assessed amounts that are more than five times the original fees. Only one assessment has been levied so far for the year 1981-82. Some knowledgeable observers expect ultimate assessments for 1981-82 to be far greater than the one assessment levied on November 9, 1984. The assessments, as a percentage of fees, are shown in Table 5.

Each of the assessments recognizes losses and expenses that had been incurred to the date of the assessment. They do not include losses that had been incurred but had not yet been reported. With allowance for losses that have been incurred but not yet reported it seems likely — almost certain — that substantial additional assessments will be levied for most or all fiscal years 1976-77 through 1982-83.

A report by the actuarial consulting firm, Tillinghast, Nelson and Warren, Inc., dated December 12, 1983 indicates an estimated deficit to the Fund for the

Table 3. — Total Assessments Levied Against Doctors for Various Fiscal Years.

	Doctors					
	Class 1	Class 2	Class 3	Class 4	Class 5	Total
1976-77	$ 788,495	$ 74,887	$ 1,024.876	Class 4 and Class 5 became classifications starting July 1, 1982.		$ 1,888,258
1977-78	839,910	457,172	1,901,415			3,198,497
1978-79	177,375	503,398	828,032			1,508,805
1979-80	860,170	876,207	1,625,305			3,361,682
1980-81	1,530,442	800,016	1,991,775			4,322,233
1981-82	1,370,667	1,974,946	6,476,422			9,822,035
Total	$5,567,059	$4,686,626	$13,847,825			$24,101,510

Note: Assessments levied against doctors who were members for the 1978-79 fiscal year are lower than for the preceding year and for the subsequent year. Many of these doctors were paying a second year fee of $500 rather than a first year fee of $1,000. Some also had greater credit for greater underlying limits. Assessments were limited to 100% of fees.

Table 4. — Assessments Levied Against Providers Other than Doctors in Various Fiscal Years to March 31, 1984.

	Hospitals	Health Maintenance Organizations	Ambulatory Surgical Centers	Professional Associations	Total All Providers*
1976-77	$ 2,096,820	None	$ 2,524	$ 41,206	$ 4,028,808
1977-78	8,800,151	$ 4,426	9,481	202,698	12,215,253
1978-79	23,977,548	22,637	70,088	302,400	25,881,478
1979-80	30,953,486	78,380	145,355	403,947	34,942,850
1980-81	32,990,609	78,881	174,150	485,335	38,051,208
1981-82	44,378,629	150,994	151,499	576,012	55,079,169
Total	$143,197,243	$335,318	$553,097	$2,011,598	$170,198,766

*Including doctors, Table 3.

years 1975-76 through 1982-83 of $319 million. Fees and assessments received have been taken into consideration in making this estimate. A report dated March 6, 1984 by Gary Granoff of Granoff Resources indicates an estimated deficit of $387 million. Estimates of future assessments to be levied against members of the Fund for fiscal years 1975-76 through 1982-83 are made by me on the basis of the two reports.[2]

	Based on Tillinghast, Nelson and Warren, Inc. Estimate	Based on Granoff Resources Estimate
Ultimate losses	$425,084,000	$492,793,000
Other expenses	2,888,000	2,788,000
	$427,972,000	$495,581,000
Fees and interest	108,414,000	108,414,000
Assessments levied	179,199,000	170,199,000
	$287,613,000	$278,613,000
Estimated future additional assessments	$146,471,000	$204,180,000

On the basis of ultimate losses and expenses estimated by Tillinghast, Nelson and Warren, Inc., and by Granoff Resources, and on fees and interest, and assessments levied, it is estimated that further assessments ranging from $146 million to $204 million will be levied for fiscal years 1975-76 through 1982-83. Since all of this would presumably be levied against hospitals, health maintenance organizations and ambulatory surgical centers, the total assessments to these providers could exceed 15 times their original membership fees.

In informal conversation informed insurance executives have said that the amounts and frequency of awards in medical malpractice cases in Florida in

Table 5. — Assessments Levied Against Providers in Various Years as Percentages of Fees Paid in Each Year (Including Assessments and Reassessments Levied to November 9, 1984).

Membership Year	Doctors	Professional Associations	Hospitals	Ambulatory Surgical Centers	Health Maintenance Organizations
1976-77	100.0	47.1	47.1	47.1	
1977-78	100.2*	99.8	305.8	99.0	100.1
1978-79	100.0	100.0	426.01	426.1	526.1
1979-80	100.0	100.0	580.6	580.6	580.7
1980-81	100.0	100.0	844.3	859.0	849.5
1981-82	100.0	100.0	201.5	211.0	211.2

*Rounding error perhaps. Assessments of doctors is limited to 100% of fees paid.

Source: "Assessments," an unaudited document prepared by employees of the Patient's Compensation Fund and a telephone conversation with Ms. Penny Lacayo February 4, 1985.

Table 6. — Number of Doctors Who Were Members of the Florida Patient's Compensation Fund in Various Years.

	Class 1	Class 2	Class 3	Class 4	Class 5	Total*
1975-76	545	71	947			1,563
1976-77	1,098	119	1,457			2,674
1977-78	1,396	808	1,583			3,787
1978-79	1,517	970	1,689			4,176
1979-80	1,676	1,123	1,867			4,666
1980-81	2,479	1,019	1,969			5,467
1981-82	1,922	1,708	1,792			5,442
1982-83	1,790	277	218	228	315	2,828
1983-84	None	None	None	None	None	None

*Source: "Indemnity Expense" report as of 3/31/84, Florida Patient's Compensation Fund. An unaudited report prepared for managerial purposes only.

the past year have substantially exceeded forecasts. Since this recent information was not available at the time the Tillinghast, Nelson and Warren, Inc., and Granoff Associates reviews were prepared it seems possible — even likely — that the deficit to the Fund may be substantially greater than the estimates shown. Estimated deficits of $100 to $200 million greater have been mentioned. While these higher estimates have not been documented, nor attested to by actuaries, they are not without significance.

Membership in the Fund • There are five broad classifications of membership in the Fund.

Doctors, osteopaths and podiatrists

Professional associations, partnerships, corporations, joint ventures, or other professional activity

Hospitals

Health maintenance organizations

Ambulatory surgical centers and other medical facilities.

For the first three years of operation of the Fund, 1975-76 through 1977-78, all doctors, osteopaths and podiatrists who were members were required to pay the same fees.[3] For the next three years, 1978-82, there were three classes of doctors with different fees for each classification.

Class 1	No surgery
Class 2	Minor surgery
Class 3	Major surgery

For fiscal years 1979-80, 1980-81 and 1981-82 two geographical classifications were created: (1) Dade and Broward Counties and (2) the remainder of the state. For 1982-83 and 1983-84 there were three geographical classifications: (1) Dade and Broward Counties, (2) Palm Beach, Pinellas, Duval, Hillsborough and Orange Counties, and (3) the remainder of the state. The number of classifications of doctors was increased to five: (1) no surgery, (2) minor surgery, (3) major surgery except Class 4 and Class 5, (4) cardiovascular surgery, orthopedic surgery, vascular surgery, and (5) anesthesiology, obstetrics, obstetrics/gynecology, neurosurgery. Fees for members in those classifications are shown in Table 1. The number of doctors in each classification who were members of the Fund in various years are shown in Table 6.

The number of doctors who were members of the Fund increased from 1,563 in 1975-76 to 5,442 in 1981-82 and decreased by 50% to 2,828 for 1982-83. No doctors have been members since June 30, 1983. The number of doctors applying for membership was not large enough for 1983-84 to provide membership fees of $5 million as required by statute for continued coverage of doctors.

The number of hospitals that were members of the Fund increased from 72 in 1975-76 to 124 in 1980-81 and decreased to 120 in 1981-82. As of July 1, 1982 all hospitals remaining in the Fund withdrew. Membership by fiscal year is shown in Table 7.

Possible liability of doctors • In view of substantial deficits to the Fund and resistance of hospital officials to payment of assessments that have been levied,[4] a question arises as to the possible liabilities of doctors who have been members of the Fund and against whom claims may be brought successfully. If the Fund does not have the resources to pay the claims, will the doctors be directly liable for them?

A doctor against whom claim is brought successfully and against whom an award is made might argue that the provision of Section 768.54 of the statutes specifically limits his or her liability to the amount of underlying insurance coverage, and the Fund is responsible for any claims above the underlying coverage. The claimant might argue that the statute cannot take away the right to just compensation for injury and that the award is a responsibility of the doctor. Some observers believe that some doctors may be held responsible for the awards and may have to pay them if resources of the Fund are inadequate. The question has not been answered in court.

The situation is somewhat different for fiscal year 1982-83 than for other fiscal years. In 1982-83, 2,828 doctors were members of the Fund and no hospitals were members. Thus, there are no hospitals to be assessed for valid claims against doctors in excess of doctors' fees (or premiums) and assessments.

The Florida Medical Malpractice Joint Underwriting Association ● The Florida Medical Malpractice Joint Underwriting Association is an association of insurance companies and self-insurers that write casualty insurance in Florida. The Association operates under the supervision of a Board of Governors consisting of representatives of five of the insurers participating in the Association, an attorney named by the Florida Bar, a physician named by the Florida Medical Association and a representative named by the Florida Hospital Association. In 1985 the St. Paul Fire and Marine Insurance Company issues policies on behalf of the Florida Medical Malpractice Joint Underwriting Association and provides settlement of claim service under a contract entered into with the Board of Governors.[5] If the Association incurs a deficit for a fiscal year each policyholder for that fiscal year is subject to assessment not to exceed one third of its regular annual payment to the Association. If there is any remaining deficit after assessment of policyholders the excess is to be recoverd from member insurers. Thus, the Association has sufficient resources to meet virtually any possible level of losses and expenses.

It appears that the Florida Medical Malpractice Joint Underwriting Association has operated successfully and has not experienced the large losses incurred by the Florida Patient's Compensation Fund. However, assessment of policyholders for some prior years is considered a possibility.

Table 7. — Number of Hospitals That Were Members of the Florida Patient's Compensation Fund, and Number of Beds.

	Number Hospitals*	Number Beds**
1975-78	72	6,460
1976-77	111	15,179
1977-78	121	17,498
1978-79	128	19,148
1979-80	129	20,537
1980-81	124	19,932
1981-82	120	20,009
1982-83	None	None
1983-84	None	None

*Source: "Indemnity Expense" report as of 3/31/84, Florida Patient's Compensation Fund. An unaudited report prepared for managerial purposes only.

**Source: A review of the Fund by the firm Tillinghast, Nelson and Warren, Inc., presented to the General Manager, December 2, 1983, Exhibit XIV.

References

1. For simplicity of expression individual practioners are referred to as doctors in this paper.
2. As of February 5, 1985.
3. Though credit has always been given for underlying coverage greater than the minimum required; thus, those with higher underlying coverage paid lower fees to the Fund.
4. A number of cases have come before the Florida courts in which the Florida Patient's Compensation Fund has brought suit against hospitals that have resisted assessments. Some of these cases have been decided in favor of the Fund and some have not yet been adjudicated. No hospital has yet prevailed in any of the suits.
5. Other insurance companies have performed this function in some prior years

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AFTER BREAKTHROUGH BLEEDING AND AMENORRHEA . . .
SHE'S ABOUT TO GIVE UP ON ORAL CONTRACEPTION.

NORLESTRIN®

(1 mg norethindrone acetate and 50 mcg ethinyl estradiol tablets, USP) 1/50

BECAUSE SOMETIMES A 50 IS PREFERABLE.

[illegible] brief [illegible] of prescribing inf[illegible]

Brief Summary of Prescribing Information
NORLESTRIN® (norethindrone acetate and ethinyl estradiol tablets, USP)

See section under **Special Notes on Administration and HOW SUPPLIED.**
Before prescribing, please see full prescribing information. A Brief Summary follows

DESCRIPTION
Norlestrin Products are progestogen-estrogen combinations.

INDICATIONS AND USAGE
Norlestrin Products are indicated for the prevention of pregnancy in women who elect to use oral contraceptives as a method of contraception.

In clinical trials with Norlestrin 1/50 involving 25,983 therapy cycles, there was a pregnancy rate of 0.05 per 100 woman-years; in clinical trials with Norlestrin 2.5/50 involving 96,388 cycles, there was a pregnancy rate of 0.22 per 100 woman-years.

Dose-Related Risk of Thromboembolism from Oral Contraceptives: Studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. It is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance.

CONTRAINDICATIONS
1. Thrombophlebitis or thromboembolic disorders
2. A past history of deep-vein thrombophlebitis or thromboembolic disorders
3. Cerebral vascular or coronary artery disease
4. Known or suspected carcinoma of the breast
5. Known or suspected estrogen-dependent neoplasia
6. Undiagnosed abnormal genital bleeding
7. Known or suspected pregnancy (See WARNING No. 5)
8. Benign or malignant liver tumor which developed during the use of oral contraceptives or other estrogen-containing products

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. The risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. *Thromboembolic Disorders and Other Vascular Problems.* An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well-established. Studies have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic.

Cerebrovascular Disorders: In a collaborative study in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than nonusers, and the risk of thrombotic stroke was 4.0 to 9.5 times greater.

Myocardial Infarction: An increased risk of myocardial infarction associated with oral contraceptives has been reported confirming a previously suspected association. These studies found that the greater the number of underlying risk factors (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia) for coronary artery disease, the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however were found to be a clear additional risk factor.

It has been estimated that users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are smokers have about a fivefold increased risk of fatal infarction compared to users who do not smoke, but about a tenfold to twelvefold increased risk compared to nonusers who do not smoke. The amount of smoking is also an important factor.

Risk of Dose: In an analysis of data, British investigators concluded that the risk of thromboembolism, including coronary thrombosis, is directly related to the dose of estrogen used in oral contraceptives, however, the quantity of estrogen may not be the sole factor involved.

Persistence of Risk: Two studies have suggested that an increased risk may persist for as long as 6 years after discontinuation of oral contraceptive use for cerebrovascular disease and 9 years for myocardial infarction. In addition, a prospective study suggested the persistence of risk for subarachnoid hemorrhage.

Estimate of Excess Mortality from Circulatory Diseases: The risk of diseases of the circulatory system is concentrated in older women, in those with a long duration of use, and in cigarette smokers.

A study of available data from a variety of sources concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke.

The risk of thromboembolic and thrombotic diseases associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia, and especially by cigarette smoking.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders. Should any occur or be suspected, the drug should be discontinued immediately.

A fourfold to sixfold increased risk of postsurgery thromboembolic complications has been reported in users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization.

2. *Ocular Lesions.* Neuro-ocular lesions, such as optic neuritis or retinal thrombosis, have been associated with the use of oral contraceptives. Discontinue the oral contraceptive if there is unexplained sudden or gradual, partial or complete loss of vision, onset of proptosis or diplopia, papilledema, or retinal vascular lesions.

3. *Carcinoma.* Long-term continuous administration of estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver.

In humans, an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women has been reported. However, there is no evidence suggesting increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives.

Studies found no evidence of increase in breast cancer in women taking oral contraceptives; however, an excess risk in users with documented benign breast disease was reported.

There is no confirmed evidence of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of users is, nevertheless, essential. In cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer, or who have breast nodules, fibrocystic disease, or abnormal mammograms, should be monitored with particular care.

4. *Hepatic Tumors.* Benign hepatic adenomas have been found to be associated with oral contraceptives. Because hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage, they should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time.

5. *Usage in or Immediately Preceding Pregnancy, Birth Defects in Offspring, and Malignancy in Female Offspring.* During early pregnancy female sex hormones may seriously damage the offspring.

An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of oral contraceptives in pregnancy.

There is some evidence that triploidy and possible other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives.

Pregnancy should be ruled out before continuing an oral contraceptive in any patient who has missed two consecutive menstrual periods. If the patient has not adhered to the schedule, the possibility of pregnancy should be considered at the time of the first missed period, and oral contraceptives should be withheld until pregnancy has been ruled out. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed.

Women who discontinue oral contraceptives with the intent of becoming pregnant should use an alternate form of contraception for a period of time before attempting to conceive.

Administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. *Gallbladder Disease.* Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives.

7. *Carbohydrate and Lipid Metabolic Effects.* Because decreased glucose tolerance has been observed in a significant percentage of patients, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed.

8. *Elevated Blood Pressure.* An increase in blood pressure has been reported in patients receiving oral contraceptives. The prevalence in users increases with longer exposure. Age is also strongly correlated with development of hypertension. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure.

9. *Headache.* Onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe requires discontinuation of oral contraceptives.

10. *Bleeding Irregularities.* Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, nonfunctional causes should be borne in mind. In undiagnosed abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy.

Women with a past history of oligomenorrhea or secondary amenorrhea, or young women without regular cycles should be advised that they may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives.

11. *Ectopic Pregnancy.* Ectopic as well as intrauterine pregnancy may occur in contraceptive failures.

12. *Breast-Feeding.* Oral contraceptives may interfere with lactation. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs.

PRECAUTIONS
1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another examination.
2. Preexisting uterine leiomyomata may increase in size.
3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree.
4. Oral contraceptives may cause fluid retention and should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated.
5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice. If jaundice develops, the medication should be discontinued.
6. Steroid hormones may be poorly metabolized and should be administered with caution in patients with impaired liver function.
7. Users may have disturbances in normal tryptophan metabolism, which may result in a relative pyridoxine deficiency.
8. Serum folate levels may be depressed.
9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted.
10. Certain endocrine and liver function tests and blood components may be affected.
(a) Increased sulfobromophthalein retention. (b) Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. (c) Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone. (d) Decreased pregnanediol excretion. (e) Reduced response to metyrapone test.

Drug Interactions: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, tetracycline, and ampicillin.

ADVERSE REACTIONS
An increased risk of the following serious adverse reactions has been associated with oral contraceptives: thrombophlebitis, pulmonary embolism; coronary thrombosis, cerebral thrombosis, cerebral hemorrhage, hypertension, gallbladder disease, benign hepatomas, congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: mesenteric thrombosis, neuro-ocular lesions, eg, retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related: nausea and/or vomiting, usually the most common adverse reactions, occur in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally: gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea, amenorrhea during and after treatment; temporary infertility after discontinuance of treatment; edema; chloasma or melasma, breast changes; change in weight; change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice; migraine; increase in size of uterine leiomyomata; rash (allergic); mental depression; reduced tolerance to carbohydrates; vaginal candidiasis; change in corneal curvature; intolerance to contact lenses.

The following adverse reactions have been reported and the association has been neither confirmed nor refuted: premenstrual-like syndrome; cataracts; changes in libido; chorea; changes in appetite; cystitis-like syndrome; headache; nervousness; dizziness; hirsutism; loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruption; vaginitis; porphyria.

Special Notes on Administration
Menstruation usually begins two or three days, but may begin as late as the fourth or fifth day, after discontinuing medication.

After several months on treatment, bleeding may be reduced to a point of virtual absence; reduced flow may be a result of medication and not indicative of pregnancy.

HOW SUPPLIED
Norlestrin [21] 1/50 is available in compacts each containing 21 tablets. Each tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin [21] 2.5/50 is available in compacts each containing 21 tablets. Each tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin [Fe] 1/50 is available in compacts each containing 21 yellow tablets and 7 brown tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin [FE] 2.5/50 is available in compacts each containing 21 pink tablets and 7 brown tablets. Each pink tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin [28] 1/50 is available in compacts each containing 21 yellow tablets and 7 white inert tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

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Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

2/84

Florida Chapter, American Academy of Pediatrics
Louis St. Petery Jr., M.D.
Saturday, 9:00-12:00 p.m.

Florida Association of Pediatric Cardiologists
David Epstein, M.D.
Saturday, 8:00-12:00 p.m.

Florida Society of Plastic and Reconstructive Surgeons
Lawrence Robbins, M.D.
Saturday, 8:00-12:00 p.m.

Florida Society for Preventive Medicine
Stephen King, M.D.
Saturday, 8:00-12:00 p.m.

Florida Chapter, American Psychiatric Association
Juan Rodriguez, M.D.
Friday, 7:30-10:45 a.m.

Florida Radiologic Society
William Kieffer, M.D.
Friday, 1:30-5:30 p.m.
Saturday, 8:00-12:00 noon

Florida Society of Rheumatology
Mike Mass, M.D.
Friday, 1:30-5:30 p.m.

Florida Chapter, American College of Surgeons
John O. Gage, M.D.
Friday, 2:00-5:00 p.m.

Florida Association of General Surgeons
William Hartley, M.D.
Friday, 2:00-5:00 p.m.

Florida Thoracic Society
John Ibach Jr., M.D.
Thursday, 1:30-4:30 p.m.

Florida Thoracic and Cardiovascular Surgeons
Douglas Pupello, M.D.
Friday, 1:30-5:30 p.m.

Florida Urologic Society
David Drylie, M.D.
Saturday, 9:00-12:00 noon

FMF Committee on Impaired Physicians
Arvey I. Rogers, M.D.
Joan Barice, M.D.
Thursday, 1:00-4:00 p.m.

Video health fair — a new concept in public service by the medical profession

On April 19, 1985, the Lee County Medical Society and WINK-TV, the southwest Florida CBS affiliate, will make Florida history by participating in a day long project to educate the public in medical matters and thereby make the public wiser medical consumers.

The project will make a phone bank of physicians available to the public. Anyone can call in and speak directly to a physician on any medical matter. Physicians will be on the line from 9:00 a.m. until 11:00 p.m. and will dispense free health and medical advice to callers. Throughout the day, WINK-TV will have cut-ins reminding the public to call.

During three separate hour long time slots, (10-11:00 a.m., 4-5:00 p.m. and 8-9:00 p.m.) programming will be given over to the medical profession for presentation on a wide variety of medical subjects.

Medical society representatives will be discussing self-care, life-styles, wellness and how to find a doctor. Scores of other more specific medical matters including lowering costs and programs on medical care will be explored.

Over 100 physicians have volunteered their time by giving four hours to participate in this project. Enthusiasm of the medical society is extremely high.

DEAN'S MESSAGE

Erroneous Perception

From October 9th to the 14th, 1984, I was privileged to be an invited guest to the Florida Medical Association's Fall Board of Governors Meeting. Although this was only the second time I was able to attend, the University of Miami School of Medicine is represented annually. I was impressed with the fact that the major objective of the FMA's leadership is to assure that the citizens of our State receive the best possible medical care.[1] The Executive Committee and the Board are composed of physicians who are knowledgeable about most of the major challenges facing medicine. However, there are some issues that are not well understood by the membership and attempts to deal with such topics could be based on erroneous perceptions and not the facts. Two specific examples are the complexities of the foreign medical graduate issue and how the FMA can have meaningful input in assisting medical centers to improve the

quality of medical education. In the case of the former, members are not sufficiently informed to recognize the ramifications of this problem. Failure to resolve this problem in a reasonable and equitable manner could severely diminish the quality of medical care provided in the State. Not only is organized medicine uninformed, but so is government (federal and state), licensure boards and many medical schools. The issue is extremely complex and clouded by a great deal of emotion. I will not attempt to review the foreign medical graduate problem in this brief note, but refer the reader to a series of articles which appeared in the July issue of the *New York State Journal of Medicine.*[2]

I am more concerned about the apparent perceptions that "some" physicians have about medical education and, more important, its product — new physicians. Over the past year, a FMA Committee on Programs and Priorities held five regional meetings in Jacksonville, Pensacola, Orlando, Tampa and Miami. The Committee asked practicing physicians their views of medical education. The list of physician comments presented to the leadership of Florida's three medical schools was disappointing.

Their statements fall into three general categories. First, that medical schools are concerned only with premedical GPAs and MCAT scores. Secondly, today's students, undergraduate and postgraduate (interns and residents), are not taught anything about the art or business aspects of medicine. Third, that the medical school's approach to Continuing Medical Education is less than satisfactory. Finally, there is an implication that the quality of new physicians graduating and/or going into practice is not as good as it could be.

I am aware that the Committee did not conduct a scientific study. Moreover, attendance at a series of meetings by a few professionals who apparently have some negative impressions does not mean that their attitudes represent those of the profession. Nevertheless, I feel compelled to respond and provide my own perceptions. I cannot speak for the University of Florida or the University of South Florida Colleges of Medicine, but I am certain that their students are as equally outstanding as those at the University of Miami School of Medicine. Students are bright, and have excellent academic records. But, more important, they are dedicated, compassionate an constructive. They will do honor to our noble profession.[3] My impressions of the men and women in our Medical Center's JMH and VAMC postgraduate training program is that the trainees truly care about their patients and their profession. They have taken a leadership position in cost containment and understand the ramifications of new federal legislation. Their concerns expressed to the hospital administration are how to provide a better quality of care more efficiently. Do we have problems in academic centers? The answer is yes. One of them is a marvelous problem — How do you select postgraduate trainees when you are presented with many of the best and the brightest medical school graduates? This past year we filled every position at the University of Miami/Jackson Memorial Medical Center. Understandably, many qualified students did not make it. However, as with the selection process for undergraduates, major consideration was given to the more subtle, personal qualities of each applicant. All serious candidates have at least one interview, each has letters of personal recommendation, and each has confidential evaluations from pre-medical advisors or, in the case of medical graduates, their medical schools.

If there is a fair criticism voiced by the physicians at these regional meetings, it is that not enough attention is given, in any of the postgraduate curricula, to the practical business aspects required by future physicians. Undergraduate students should be familiar with issues facing the health professions. However, with periods ranging from a few years to eight years before entering practice, it is not an efficient use of time to provide much training at the undergraduate level. On the other hand, residents and fellows should receive an orientation into the realities of practice. It is my opinion this can be accomplished best by utilizing the experience of practicing physicians. I invite the FMA to join us in developing such a curriculum that could be provided on a clinical division basis during grand rounds to our trainees.

The teaching of medical ethics has already been successfully implemented. At the University of Miami School of Medicine we have a required course entitled "Health & Human Values." It is a program which has evolved over the past ten years and is provided one hundred hours in our curriculum. A future publication of the Dean's Message will present this critically important aspect of our curriculum. Relative to this issue is the substantial curriculum revision that is going on in our institution and every school of medicine. Long before the AAMC issue of the General Professional Education of the Physician Report, our school had initiated most, if not all, their recommendations. However, much remains to be done.

Finally, the issue of Continuing Medical Education. For years I have heard how the grand rounds should be televised to physicians' offices. Several pilot projects of this type have been tried in this country. All have failed. Last year our school conducted 95 CME programs and had 8,093 registrants. The school has instituted a policy of inviting clinical volunteer faculty to these meetings and not charging a registration fee (except preparatory courses for certified boards). The school also participated with the DCMA and local hospitals in on-site training. The fact is that physicians who wish to have continuing education get it on a regular basis. My opinion is

that you cannot legislate such education, and mandatory hours will not force the few physicians who do not keep up to participate. All that the medical schools can do is to make certain that they provide high quality CME that is accessible to the practicing physician.

I am pleased that the Committee has brought these concerns to the attention of the schools. They point out that communication is poor, that greater collaboration and understanding between the practicing physician and the academic health centers are essential. Medical schools must be aware of what goes on in the community. The community and, especially our professional colleagues, must understand the complex challenges that face academic medicine. Not only are we confronted with the same federal regulation of the practice of medicine, but we must teach and seek new knowledge at a time when no one wants to take financial responsibility for these essential activities. Without the support and understanding of the profession, we cannot hope to solve the problems. Together we can do the job successfully.

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2. The Offshore Medical Schools, New York State Journal of Medicine, Vol. 84, No. 7.
3. Fogel, B.J., Reflections On This Year's Medical School Graduation, J.F.M.A., 71:416, 1984

Bernard J. Fogel, M.D.
Vice President for
Medical Affairs
Dean, University of Miami
School of Medicine

WORTH REPEATING

ADAMHA stressing prevention studies

The year 1984 saw several notable advances in the alcohol, drug abuse and mental health fields.

Basic research studies in the neurosciences continued, with scientists seizing opportunities to study the effects of alcohol and drugs and mental disorders on brain function. The trend to neuroscientific approaches to understanding and treating these disorders is being fueled by sophisticated new research techniques and the opening of new frontiers in knowledge.

Prevention came to the forefront of the agency's research efforts. The first annual report to Congress on Alcohol, Drug Abuse and Mental Health Administration's (ADAMHA) prevention activities showed that in fiscal 1983 the agency spent more on prevention research than ever before: $14 million for 118 projects, compared with $6.3 million in fiscal 1980, as these fields moved to develop scientific underpinnings for prevention efforts.

A new study completed for the agency by the Research Triangle Institute estimates that the cost to the economy of the abuse of alcohol and drugs and mental illness totals $190.7 billion (for 1980). This all-time high total reflects improved methods of estimation and factors related to inflation and population growth. It includes direct costs of treatment from accidents, injuries and increases in morbidity, and indirect costs stemming from lost and reduced productivity and other factors.

Alcohol abuse costs are estimated at $89.5 billion; drug abuse at $46.9 billion, and mental illness at $54.2 billion of the total.

A landmark survey of the nation's mental health - the largest and most comprehensive ever - found that one in five Americans suffers a psychiatric disorder in the course of six months. The National Institute of Mental Health survey of nearly 17,000 persons in New Haven, Baltimore, and St. Louis included schizophrenia, anxiety disorders such as phobias and panic, the depressions, severe cognitive impairments, antisocial personality disorders, and alcohol and drug abuse disorders.

The year was also marked by Secretary Margaret M. Heckler's release of the DHHS Task Force Report on Alzheimer's disease and her announcement of accelerating research, examining respite care for families of victims, and reforming medicare coverage for Alzheimer's treatment.

We convened the second annual conference for youth on drinking and driving, focusing on alcohol abuse among students who hold jobs, and programs for them in the workplace.

The Fifth Alcohol and Health Report submitted to Congress indicated that the prevention of alcohol abuse is becoming more important as awareness grows that alcohol problems can be present in the entire drinking population.

Among promising future directions are improved early identification of potential problem drinkers and alcoholics and expanding basic knowledge of just how and why alcohol abuse is so destructive. Treatment findings indicate that programs should be tailored to meet the needs of different types of clients.

The National Institute of Mental Health reported on progress in the neurosciences, including findings on brain function in schizophrenics and a skill cell test for certain depressive subtypes. The National Institute on Drug Abuse ninth annual survey of high school seniors in the U.S. indicated that daily marijuana use declined for the fifth consecutive

year, with one out of 18 seniors still reporting daily use.

These and other developments in the field of alcohol and drug abuse are reported elsewhere in this issue, in institute reports that follow.

National Institute on Alcohol Abuse and Alcoholism • The economic, social and human costs of alcohol abuse and alcoholism are devastating to our society. Approximately 10 million American adults are problem drinkers (including those who suffer from alcoholism).

In addition, some 3 million young people 14 to 17 years old have problems with the use of alcohol. Considering the lives of family, friends, employers, co-workers and innocent bystanders, countless numbers of Americans are affected.

There is dramatic evidence of this major public health problem:

- Studies indicate that two-thirds of the adult population consumes alcoholic beverages, with the heaviest drinking one-third accounting for over 95 percent of total consumption.
- Based on findings by the Congressional Office of Technology Assessment, alcohol abuse may be responsible for up to 15 percent of the nation's health care costs.
- Liver cirrhosis — most often related to alcohol abuse — was the eighth leading cause of death in the United States in 1980.
- Traffic accidents are the greatest cause of violent death in the United States. Up to half of the deaths resulting from traffic accidents are alcohol-related.
- For adults aged 25 to 44, accidents are the leading cause of death by a significant margin over the second and third leading causes — cancer and heart disease. Between one-third and one-half of adult Americans involved in accidents, crimes and suicides have been drinking alcohol prior to the event.
- The children of alcoholics are at significantly increased risk for alcohol abuse and alcoholism and for other alcohol-related problems.

The economic costs to society of alcohol abuse and alcoholism are also appallingly high. The most recent estimate (1980) is $89.5 billion a year resulting from lost employment and reduced productivity, health care, crime, motor vehicle crashes and excess morbidity and mortality.

NIAAA adopted a major priority — to focus resources on alcohol and drug-related safety issues. Despite the variety of settings in which accidents occur, a common thread among them is the frequency with which alcohol and drugs are involved.

This project will involve all components of the institute including extramural and intramural research, research dissemination and prevention. Collaboration was invited with the National Institute on Drug Abuse; other federal departments such as Transportation and Defense and the National Transportation Safety Board; and private sector businesses and industry concerned with safety issues, such as the General Motors Corporation, with which preliminary talks already have been held.

The new safety project will include such activities as research to assess the extent of alcohol and drug involvement in a variety of accidents; advancing the state of knowledge regarding alcohol, drugs, and various types of trauma; and developing techniques to more effectively prevent and reduce alcohol-related accidents. The institute will encourage investigators to develop and submit applications on various aspects of the alcohol and drug safety issue and will conduct research on impairment levels and related topics in the institute's intramural research program.

In the prevention area, NIAAA established a panel of alcohol prevention experts to review NIAAA's prevention efforts and to provide recommendations on ways to use the insitute's limited resources most effectively for prevention-related activities. The panel's recommendations, submitted to the director in July, will be carefully considered as the institute plans its future prevention programs.

In the short-term, the institute focused its prevention and health promotion activities on the prevention of alcohol abuse among our nation's young people. Building upon the success of its 1982 educational campaign, the institute has plans to prepare a public education campaign directed toward youth and persons who care for them.

The campaign will assist in the development of attitudes and skills necessary to prevent youth from developing problems with alcohol and will enlist parents and teachers in the reinforcement of these attitudes and skills. It is planned for release in late 1985 and will include print and broadcast messages and community-based programs implemented through the States.

As the 1984 American Assembly at Columbia University concluded, "the greatest hope for significant improvement in the alcohol field lies in more and better research." NIAAA, as its primary mission, focuses on research and the dissemination of research findings to the alcohol and related health fields and the general public.

Biomedical and behavioral research is aimed at building a solid base of knowledge about alcohol abuse and alcoholism which can lead to better treatment and more effective prevention approaches.

The heritability of alcoholism continues to be a fertile field. A genetic basis for alcoholism, apparently fanciful theory only a decade ago, is being

scientifically confirmed and solidified. There is convincing evidence of a genetic predisposition to alcoholism in perhaps 40 to 50 percent of alcoholic patients.

One of the most challenging tasks facing the alcohol field, and the institute's intra- and extramural research programs, is to find out precisely what is inherited and how nature and nuture interact to produce alcoholic disease.

Individuals vary genetically in their ability to metabolize alcohol. For example, some Asians are prone to an uncomfortable "flush" reaction to alcohol. Now researchers have found a link between alcohol flush and the genetic absence of a specific enzyme.

Research in the neurosciences is beginning to suggest powerful links between neurobiology and responses to alcohol. For example, alcohol clearly alters the physical properties of nerve cell membranes. When alcohol is present, membranes become more fluid. But, with chronic use, the membrane composition becomes more rigid.

This phenomenon suggests a possible biochemical basis for tolerance. Several studies indicate genetic variability in sensitivity to the membrane effects. This may lead to understanding a possible precursor to alcoholism.

The institute's newly created Laboratory of Clinical Studies, which opened in October of 1983 on the campus of the National Institutes of Health, has begun its focus on the familial transmission of alcoholism, i.e., the extent to which alcoholism is transmitted in families and why. Aided by a 10-bed inpatient facility in the NIH Clinical Center and an outpatient program, the laboratory's current and future research plans include the study of such areas as the diagnosis, and treatment of alcohol abuse and alcoholism; alcohol-related medical conditions such as the Werneke-Korsakoff syndrome; and the way in which alcohol affects various body systems, with particular emphasis on the way alcohol affects motor coordination and judgment.

It is now clear that alcohol can affect the developing fetus adversely. Pregnant women who drink heavily risk mental retardation and growth deficits in their infants. The task ahead is to define the amount of drinking and the timing during pregnancy that leads to developmental problems.

Alcoholism treatment, the efficacy of various treatment modalities, and treatment outcome assessment are important issues requiring a sustained research effort.

National Institute on Drug Abuse • The National Institute on Drug Abuse supports drug abuse research and research training, sponsors public information and education programs and disseminates prevention and treatment information to states, communities and voluntary groups.

NIDA's public education programs include the release of research findings to the media, the support of national drug abuse prevention media campaigns and the distribution of publications through the National Clearinghouse for Drug Abuse Information.

NIDA disseminates scientific findings through a research monograph series and an extensive program of technical reviews and state-of-the-art conferences. In addition, NIDA encourages public interest groups, foundations, educational institutions and professional associations to address the drug abuse problem.

The year 1984 saw major accomplishments in all these areas.

NIDA supports three epidemiological surveys: the National Household Survey on Drug Abuse; the annual High School Senior Survey; and the Drug Abuse Warning Network (DAWN):

- The last National Household Survey in 1982 (of a representative sample of the national population) indicated a reversal or reduction of the upward trends in drug use charted by earlier surveys of the seventies.
- The 1983 National High School Senior Survey indicated that American young people are continuing to moderate their use of illicit drugs. Between 1981 and 1983, current use (use during the month preceding the survey) of nearly all classes of illicit drugs declined, with the most appreciable drops occurring in the past two years for marijuana, amphetamines and sedatives.

  Marijuana use has declined consistently since 1979 although marijuana is still the most widely used of the illicit drugs. Daily use fell to 5.5 percent, or about one in every 18 seniors. This is attributed to young people's concerns about the consequences of regular use and less peer acceptance.

  Despite the generally good news, it still appears that illicit drug use by our nation's young people is at the highest level of any nation in the industrialized world:
- Roughly two-thirds of all American young people try an illicit drug before they finish high school.
- About one in 18 seniors drinks alcohol daily, and 41 percent have had five or more drinks in a row at least once in the past two weeks.
- About 30 percent of this age group has smoked cigarettes in the prior month, a substantial proportion of whom are daily smokers. One-third of the American household population over age 12 has used marijuana, cocaine, heroin or other psychotherapeutic drugs for nonmedical purposes at some time during their lives.

NIDA also gathers information on the negative health consequences of drug use through emergency rooms and medical examiners reporting to NIDA's Drug Abuse Warning Network (DAWN). Negative health consequences associated with drug use have not abated.

During the past 3 years, the number of hospital emergency room episodes involving heroin abuse increased steadily, from 7,460 in fiscal 1981 to 11,136 in fiscal 1983. Cocaine-related episodes increased from 3,443 in fiscal 1981 to 5,394 in fiscal 1983.

NIDA-sponsored research in 1984 led to discoveries which hold promise for better understanding of drug addiction and the treatment and prevention of drug abuse.

Research on identifying and isolating opiate receptors within the central nervous system and the subsequent discovery of endogenous opiate-like substances has sparked vigorous research in drug abuse, neurological disease, mental health, cardiac function and pain and analgesia.

NIDA gave high priority to the nation's serious problem of cocaine abuse. Increases in overdose deaths and DAWN emergency room mentions, coupled with increased availability and lower price, have raised concerns about a new cocaine epidemic.

In July, NIDA held a technical review by experts on cocaine to develop a comprehensive description of patterns and consequences of cocaine use in this country.

Recent research by Dr. Roy Wise of Concordia University, Montreal, suggests that while many of the actions of cocaine and heroin in the brain are different, they share the ability to activate the same reward mechanism in the brain.

Cocaine is especially potent in activating the brain's reward system. With unlimited access to cocaine, rats will self-administer cocaine to the point of convulsion and death.

NIDA relocated its Addiction Research Center from Lexington, Ky., to Baltimore. The center conducts longterm projects such as studies on the effectiveness and safety of new treatment agents, most notably LAAM, naltrexone and buprenorphine, all of which have unique properties that contribute to better treatment for opiate dependence. Naltrexone will be marketed soon. A NIDA study showed that a depot preparation of naltrexone lasting 30 days can successfully protect an individual against a narcotic challenge.

Because of the increasing impact of drug abuse on performance in the workplace and the military, research also is aimed at developing simple, portable drug detection procedures. A kit is now available for use by chemists and laboratories for reliable, inexpensive urine screening for a variety of abused substances, including marijuana.

NIDA-supported research established that nicotine is a dependence-producing substance and shares characteristics with other substances of abuse, which produce pharmacologic and psychological effects. In particular, the euphoriant effects of nicotine are strikingly similar to those of intravenous morphine and cocaine.

Research also indicates that cigarette smoking is a gateway drug for the onset of marijuana smoking. These and other recent findings indicate that reducing young peoples' initiation into cigarette smoking can have long-term beneficial effects, not only in reducing smoking, but also in reducing use of other drugs.

NIDA funded the New York State Division of Substance Abuse to conduct the first major study to determine why intravenous drug users are the second largest risk group for AIDS, acquired immune deficiency syndrome.

In 1984, NIDA and NIAAA solicited research to assess multi-component preventive intervention programs which target both alcohol and drug abuse.

In the area of prevention, NIDA provided information, technical assistance and consultation to federal, national, state and local organizations, as well as the general public. Under the State Drug Abuse Prevention Grant Program, virtually every state and territory received a NIDA grant to carry out prevention activities.

The institute increased the health professions' awareness and participation in drug abuse prevention and treatment. It collaborated with the American Medical Association, the Association for Medical Education and Research in Substance Abuse and the National Board of Medical Examiners to establish health professions education programs and provided information and technical assistance to a variety of health professions organizations.

NIDA, together with NIAAA, is working with the American Psychiatric Association to develop more useful diagnostic constructs than are now represented in DSM-III (APA's Diagnostic and Statistical Manual, and ICD-9, the international classification system. NIDA's principal concern is that drug dependence be recognized as a neurobehavioral syndrome, without overrelying on signs of tolerance and withdrawal to make a diagnosis, as required by the current diagnostic system.

National Institute of Mental Health • In September 1984, Secretary Heckler announced the appointment of Shervert H. Frazier, M.D., of Harvard Medical School and McLean Psychiatric Hospital to serve as director of the National Institute of Mental Health. He was chosen after a national search to fill the post when Dr. Herbert Pardes left to become director of the New York State Psychiatric Institute and chairman, Department of Psychiatry, Columbia University Medical School.

The first results of the largest and most comprehensive survey of mental disorders ever conducted in the United States were released October 2. The study revealed that over a six-month period approximately 20 percent, or 29.4 million, American adults suffer from at least one psychiatric disorder.

This figure, while greater than previous survey estimates of 15 per cent prevalence of mental disorder in the United States, reflects the comprehensiveness of the survey. Alcohol and drug abuse as well as antisocial personality were included along with the anxiety, depressive and schizophrenic disorders.

The survey dispelled the long-held notion that women have higher rates of mental disorders than men. Rates for women and men were comparable, but the types of illness each characteristically develops are different. Women suffer more from depressive and anxiety disorders and men from alcohol and drug abuse and antisocial disorders.

The most prevalent mental illnesses according to the survey are anxiety disorders, which include phobias, panic disorders and obsessive-compulsive disorder. From 7 to 15 percent of the population suffers from anxiey, about 13 million persons, yet only 23 per cent of these individuals reported receiving treatment. Although some of the anxiety disorders may be relatively mild, others are so severe that afflicted individuals fear to venture outside their homes for periods of years.

Alcohol and drug abuse or dependence is found in 6 or 7 percent of the population, or 10 million persons. About four-fifths of these individuals have alcohol problems.

According to the survey, depression affects about 5 to 6 percent of the adult population, about one-third of whom receive treatment.

The surveys, involving more than 10,000 respondents, were conducted in New Haven, Baltimore and St. Louis as part of NIMH's five-city Epidemiologic Catchment Area program, begun five years ago.

Research on brain function and the neurobiological underpinnings of addictive disorders and the mental illnesses has burgeoned, bringing many medical advances.

NIMH scientists announced the development of a skin test that may detect a genetic vulnerability to manic-depressive illness. They found that manic-depressive patients and their relatives with a history of affective disorder had more receptors in their skin cells for acetylcholine – a neurotransmitter involved in depression – than their never-depressed relatives and normal controls. The findings were published in the July 26 *New England Journal of Medicine*.

At a consensus conference on mood disorders held in the spring, the panel recommended that individuals with recurrent mood disorders receive long-term preventive treatment such as lithium to prevent recurrent bouts of mania or manic/depressive disorder, and tricyclic antidepressants or lithium for recurrent unipolar depression.

Another consensus conference dealt with drug treatment for insomnia. Since sleep problems can be caused by a variety of physical and mental conditions, experts recommended, as a first step, careful and systematic diagnostic inquiry, as well as assessment and necessary correction of sleep habits.

Depending on the causes of the insomnia, a complete treatment plan could involve psychotherapeutic or behavioral approaches or pharmacology, alone or in combination. If drug treatment is deemed useful, such as in the case of short-term stress from hospitalization, work or personal problems, benziodiazepines are the treatment of choice, to be prescribed in the smallest effective dose for the shortest necessary period of time. Since these drugs can be habit forming, patients should be carefully educated and monitored by physicians.

Drugs are contraindicated for sleep apnea (interrupted breathing) and must be prescribed with great care for the elderly.

Research on schizophrenia continues to implicate an excess of dopamine in this illness. One fascinating set of studies indicates that frequency of eye blinks is emerging as an almost uncanny mirror of brain dopamine activity.

Parkinson's disease victims, who are known to suffer from a lack of dopamine, blink less often, while unmedicated schizophrenics typically blink more often than controls. NIMH researchers have found that neuroleptics reduce blink rates in schizophrenics with normal brain ventricles.

Scientists at Saint Elizabeths hospital, using a new brain imaging technique called "regional blood flow mapping," found that frontal brain lobes in schizophrenic patients respond metabolically opposite from those of a healthy person when asked to perform a simple card-sorting task. Instead of "turning on," the frontal lobes "shut down" completely, and even become less active than they had been before the command to perform.

If one compares the brain to a computer, these early findings suggest that when patients try to bring their brain "on-line" to perform a task in the logical sequence, they experience instead a "computer crash." Their frontal lobes of "off-line" and they lose access to them.

Encouraging news comes from studies on relapse rates among schizophrenics. A controlled study has compared family therapy and maintenance drug therapy with individual supportive therapy and maintenance drug therapy. After nine months, family therapy proved far more effective in preventing relapse; only 1 of 18 family-treated patients had re-

lapsed, compared to 8 of 18 individually supported patients.

A large collaborative study was funded to test the effectiveness of various drug maintenance strategies with two types of psychosocial support.

Ongoing research with the elderly has ranged from neurochemical investigations at fundamental levels of cellular function and protein synthesis to surgical and pharmacological animal models of Parkinson's disease, and longitudinal and cognitive studies of Alzheimer's victims.

In September, Secretary Heckler released the *Report of the Secretary's Task Force on Alzheimer's Disease*. The report outlined a comprehensive strategy for a research offensive against Alzheimer's disease, which strikes about 2 million persons each year. In response, the NIMH is funding several clinical research centers to focus on psychopathology of the elderly.

Funding of five new Alzheimer's Research Centers was announced, with NIMH and NINCDS to collaborate with the National Institute on Aging. This will bring the number to ten.

The report also drew special attention to the families of Alzheimer's victims.

HHS launched a new initiative on respite care. Under the initiative, current respite care studies and a demonstration project in HHS will be closely coordinated, and further projects will be funded to study respite care alternatives. HHS will also work with private, volunteer and community respite care providers.

Secretary Heckler instructed medicare contractors to end the practice of placing a $250 limit on physician services for some Alzheimer's patients.

In June, NIMH became the home of the world's first modern private facility capable of employing both sophisticated biological techniques and behavioral/ethological approaches in the study of animal models of behavioral development and mental illness.

Donald Ian MacDonald, M.D.
Administrator
Alcohol, Drug Abuse and
Mental Health Administration

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SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"The lady with breast cancer scam"

Related closely to the "Grandpa Scam" is the "Lady with the Breast Cancer Scam." This scam is being run in the rural areas around St. Louis by an organized drug dealing ring based in Jefferson County and using a lady from St. Louis who apparently really does have cancer.

The lady simply shows up one day at the physician's office and presents her case for treatment (DILAUDID is the only drug that gives her relief). She tells the physician she is staying with her daughter in a town some distance from where the physician is located. The daughter accompanies her and also requests medication (DEMEROL) for migraine headaches.

A check of the driver's license uncovered the fact that the daughter was using a false name and address. The women involved in this scam had been seeing as many as five to seven physicians on a rotating basis.

CORRECTION

"Presentation of hemophilia A in the newborn period"

The following abstract should have appeared with the article entitled "Presentation of hemophilia A in the newborn period", in the February issue, Vol. 72, No. 2, pages 99-100.

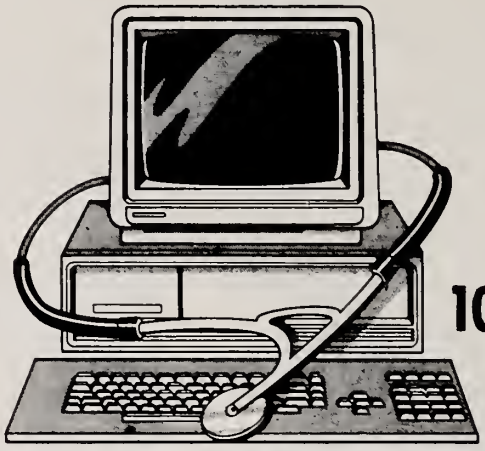
ABSTRACT: Hemorrhage in the newborn period can be due to many different causes. These causes include thrombocytopenia, vitamin K deficiency, disseminated intravascular coagulation and hemophiloid diseases. Physicians should maintain a high index of suspicion of hemophilia, since urgent diagnosis and treatment are necessary for good outcome. An illustrative case is reported.



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19th ANNUAL BENEFIT ART AND CRAFTS SHOW

THURSDAY, MAY 2 12:00 noon-4:30 p.m.
FRIDAY, MAY 3 8:30 a.m.-4:30 p.m.

EXHIBIT RULES AND REGULATIONS (Read Rules Carefully)

1. All entries must be original work.
2. Pictures must be framed and wired for hanging. (Stands will be provided for sculpture, etc.)
3. Each entry must have a typed card indicating Name, Address, Medium, Dimensions and Title. Please list price if entry is for sale; otherwise, mark not for sale (NFS).
4. Only one artist's name should be listed for each registration slip.
5. A registration fee of $10 will be charged for each entry. Entry fees are tax deductible. Entry fees will be donations to AMA-ERF, divided equally among Florida medical schools.
6. All registration slips and checks must be sent in together no later than April 13, 1985.
7. All pre-registered entries are to be delivered by hand to the Exhibit Hall at the Diplomat Resort & Country Club Wednesday, May 1, between 3:00 and 5:00 p.m. and Thursday, May 2 between 9:00 and 11:00 a.m.
   Shipped entries will be refused.
8. All entries must be picked up noon Saturday, and must be signed out before removal from the show.
9. We will not be responsible for entries not picked up by 12:00 Noon, Saturday, May 4, 1985.
10. Doctors, spouses of doctors and doctors' children are eligible to enter.

Kindly enter my registration to show in the Benefit Art and Crafts Show.

Fee of $_____ for _____ entries is enclosed. I agree to abide by the rules and regulations for exhibiting in the show.

Name _____

Address _____

City _____ County _____

I will be showing in the following categories: Please check (X) appropriate category (categories) and division applying to your entry (entries). Division: (1) Adult _____ (2) Youth _____

Category: ( ) A. Painting. Include any media in color: acrylic, oil, casein, collage, watercolor, pastel, etc.

Size: _____ (H) x _____ (W)

( ) B. Graphics. Include pen and ink, charcoal, photography, etc.

Size: _____ (H) x _____ (W)

( ) C. Crafts. Include sculpture, pottery, ceramics, mosaic, weaving, quilting, handwork, etc.

Size: _____ (L) x _____ (D) x _____ (H)

( ) I am the son/daughter of a Florida physician. Age _____

"Awards of Merit" and "Best in Show" will be judged by experts in art, photography and crafts.

An "Editor's Award," given by *The Journal of the Florida Medical Association,* will be used on the cover of a future issue of *The FMA Journal.*

A registration fee of $10 will be charged for each entry. Make checks payable to: FMA-A Art Show, P.O. Box 2411 Jacksonville, Florida 32203 (904) 356-1571.

NOTE: It is most important to know the size of your art objects, paintings, etc., to enable us to display them more professionally. We will not be responsible for damage or loss of any entry.

REGISTRATION DEADLINE — APRIL 13, 1985

Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

The silent crime — child abuse

You enter a shelter home for abused children. You look around and gauge the children's ages to be sixteen months to eight years old. The sixteen month old boy is being gently held and soothed by the eight-year-old girl. Two other little ones are seated together on a sofa huddled close to one another. They raise questioning eyes. One attempts a smile, the other seems uncertain whether or not to chance a friendly gesture. On the floor, near the television, two little girls contentedly dress their not-so-new dolls. Near the jalousied window, a four-year-old boy stands alone. You approach him, arms outstretched with the intention of hugging him. He cowers and his arm darts up to protect his head. Your are taken aback but instantly understand that his past has conditioned him to mistake a kindly gesture for blows to the face and head. Clearly you are outraged, you are devastated, and you think of the pain and sadness and the heartless treatment he must have endured in so young a life.

This scene occurred in a shelter home that provides children protection from abusive adults. Oppressive treatment of children is a widespread phenomenon of shame — a silent crime that is slowly being uncovered. Society is showing a growing concern over the ugliness that is being forced upon our children; those to whom we look for the survival of a healthy and productive future society.

As incredible as it may seem, recent years have brought to light much notoriety about young children being sexually assaulted, physically battered, and emotionally attacked. We have been shocked by reports of the child abuse crisis. The National Registry for Child Abuse in Washington, D.C. reported 1.8 million cases of child abuse in 1984; however, experts believe that the actual incidences are far greater. Child abuse is considered one of the most underreported crimes. Each year two to four thousand children die and many others suffer profound psychological damage as the result of child abuse. In Florida alone, 150,000 cases of child abuse have been reported in 1984.

What can we do about this silent crime? The Florida Medical Association Auxiliary along with its component county auxiliaries and the American Medical Association Auxiliary is in the forefront of efforts to involve volunteers in community programs and call public attention to the child abuse problem. These programs include child advocacy and parent support groups, educational seminars, parenting education, and educating young children about sexual abuse. In 1983-84 FMA Auxilians raised more than $33,000.00* statewide in which proceeds were distributed to shelter homes, resource and treatment centers, crises nurseries, and refuge houses. Fund raising activities included concerts, fashion and flower shows, seminars, and ohter events.

Everyone is urged to be aware of the signs of child abuse, and if child abuse is suspected, contact one of the local service agencies. Help for the child and family can be found through child protective agencies, social service departments, public health authorities, and the police.

In a special session convened in December 1984, the Florida Legislature approved a $5.2 million emergency package to fight child abuse and upgrade day care centers. When the 1985 Legislature convenes in April, the problem of child abuse will be a priority issue.

The time for concern and alertness to the safety of children is now. Vigilance is needed by everyone to help eradicate the silent crime of child abuse. Do you want to help? Volunteer in the Auxiliary programs, be aware of child abuse and neglect, urge anyone needing help to contact Parents Anonymous, attend parenting courses and seek counseling. Report all known or suspected child abuse to the HRS Hotline: 1-800-342-9152.

Mrs. Victor Dabby (Emily)
Dade County

*Dade County raised over $23,000.00 of this amount through a special Doctor's Day Seminar, "We speak for the Innocent," and a gala observance of "Symphony, Champagne, and Castanets" all to benefit child abuse prevention and treatment projects.

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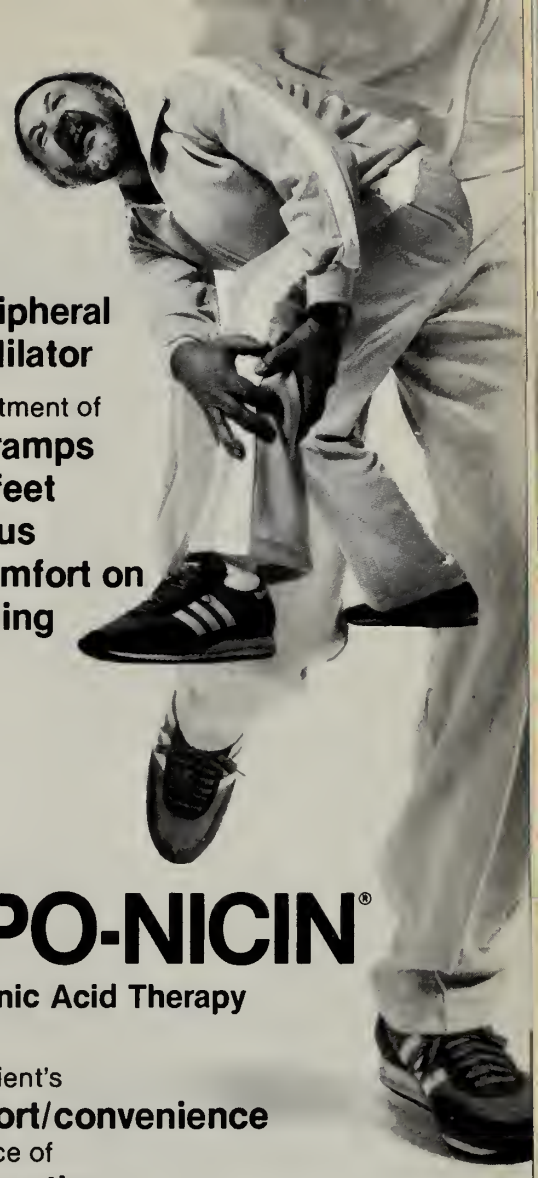
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Meetings

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APRIL

Spring 1985 Family Practice Review, April 1-5, Sheraton World Center, Orlando. For info.: William Stewart, M.D., JHMHC J-233, Gainesville 32610, (904) 392-3143.

Diabetes Workshop, April 2-3, Pelican Bay Country Club, Daytona Beach. For info: Richard Morris, M.D., 570 Memorial Circle, Ormond Beach, 904-677-3642

Interventional Radiology, 3rd Annual Seminar, Apr. 2-6, Walt Disney World Village Hotel Plaza, Lake Buena Vista. For info.: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

Tumor Conference, April 1, 16, University Com. Hospital, Tampa. For info: Michael Verlin, M.D., 3100 E. Fletcher Ave., Tampa 33612, 813-971-6000

Neuropathology Conference, April 9, 23, Univ. Com. Hospital, Tampa. For info: Glenn S. Hooper, M.D., 3100 East Fletcher Ave., Tampa 33612, 813-971-6000

Radiology Conference, April 9, Univ. Com. Hosp., Tampa. For info.: Ray Columbaro, M.D., 3100 E. Fletcher Ave., Tampa 33612, 813-971-6000.

Trends and Techniques, Apr. 10-12, Hilton Hotel, Lake Buena Vista. For information: Eileen Coulombe, JHMHC J-294, Gainesville 32610, (904) 392-2893.

Issues and Advances in Pediatrics — 1985, Apr. 10-12, Sheraton Sand Key Resort, Clearwater Bch. For information: Lewis Barness, M.D., 12901 N. 30th St., Tampa 33612, (813) 974-4214.

Seminar on Vaginal Surgery, April 10-12, Palm Beach Hilton, Palm Beach. For info: Daniel Rowe, M.D., 305-833-0348.

Seminar on Regionalized Compatability Testing, April 11-12, TBA, Tampa. For info: S.W. Fla. Blood Bank, P.O. Bkox 2125, Tampa 33601, (813) 253-0515.

7th Annual Workshop in Crisis Control, April 12, Holiday Inn, Ft. Lauderdale. For information: Cathryn Liberson, 1201 N. 37th Ave., Hollywood 33021.

Cardiology Workshop, Apr. 12, Hyatt Regency Hotel, Tampa. For info.: Joseph E. Holland, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (9]4) 398-5667.

Family Practice Weekend — Tampa, Apr. 12-14, Hyatt Regency, Tampa. For info.: Joseph Holland, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (904) 398-5667.

Diagnostic Dilemma, April 12, 26, Univ. Com. Hosp., Tampa. For information: William R. Faust, M.D., 3100 E. Fletcher Ave., Tampa 33612, 813-971-6000.

Advanced Cardiac Life Support, Apr. 13-14, Pasco-Hernando Comm. College, New Port Richey. For information: James Marlowe, M.D., P.O. Box 1058, New Port Richey 34291-1058, (813) 842-9574.

Sudden Death - Clinical and Pathological Correlation, Apr. 18-20, Bonaventure Intercontinental Hotel and Spa, Ft. Lauderdale. For information: Esther Cohen, 4300 Alton Rd., Miami Beach 33140, (305) 674-2121.

15th Annual Radiation Therapy Clinical Research Seminar, Apr. 18-20, Gainesville For info.: Hal Jacobson, M.D., JHMHC J-385, Gainesville 32610, (904) 392-3161.

The Current Status of Tissue & Mechanical Heart Valve Replacement, Apr. 27, St. Joseph's Hospital, Tampa. For info.: Dennis Pupello, M.D., 3001 W. Buffalo Ave.,

MAY

Correction of Maxillo Facial Deformities, May 10-16, Sheraton Bal Harbour, Miami. For information: ACPA. National Office, 331 Salk Hall, Univ. of P. H., P.H., PA 15261, 412-681-9620.

Current Concepts in Pain Management, May 10-29, Mississippi Steamboat Cruise. For information: Dr. Berman, 3301 Johnson St., Hollywood 33021, (305) 989-6650.

Flexible Sigmoidoscopy, May 11, JFK Memorial, Atlantis. For information: Fred R. Smith, M.D., 110 JFK Circle, Atlantis 33462, 305-964-8221.

Adolescent Pregnancy - Problems & Solutions, May 17, Palm Beach Airport Hilton, West Palm Beach. For info: Becky Myers, 5312 Broadway, West Palm Beach 33407, (305) 848-6300.

2nd Annual Lykes Cancer Center Symposium, May 17-18, Holiday Inn Surfside, Clearwater Beach. For info: Roger Lapp, P.O. Box 1027, Clearwater 33517, 813-443-1081.

Review Course for Certification in Internal Medicine, May 26-31, Kesy Biscayne Hotel, Key Biscayne. For info: Jose S. Bodes, M.D., P.O. Box 016960, Miami 33101, (305) 547-6063.

American Academy of Clinical Anesthesiologist 1985, May 29-June 1, Destin Hilton, Destin. For information: Donald Catron, M.D., P.O. Box 11619, Knoxville, TN 37939, 615-588-6279.

Master Approach to Cardiovascular Problems, May 25-27, Contemporary Hotel, Orlando. For information: Yolanda Barcena, Dept. of Medicine, Univ. of Miami, Miami 33101, (305) 549-7124.

JUNE

Neonatal & Pediatric Respiratory Disease Conference, June 6-9, Sheraton-Sand Key Resort Hotel, Clearwater Beach. For information: Myrtle Larson, R.N., Gulf Coast Lung Assn., 6160 Central Ave., St. Petersburg 33707.

American & European Views on Critical Care, June 8-15, Cannes, France. For info.: Sonja Craythorne, Dept. of Anesthesiology, Univ. of Miami, Miami 33101, (305) 547-6411.

Coronary Artery Disease and Sudden Death: Primary and Secondary Prevention, June 14-16, Hyatt Grand Cypress, Orlando. For information: Margaret Kleiger, 64 Inverness Dr. E., Englewood, CO 80112, (303) 790-8445.

Emergency Care: The Pediatrician's Turf, June 15-19, Sheraton Sand Key Hotel, Miami. For info: Gilbert Pitisci, 2902 Beach Drive, Tampa 33609.

10th Annual Florida Suncoast Pediatric Conference, June 15-19, Sheraton Sand Key Hotel, Clearwater Beach. For information: Gilbert Pitisci, M.D., 2902 Beach Dr., Tampa 33609, (813) 870-3720.

Advances in Internal Medicine, June 23-28, France. For information: Div. of CME, P.O. Box 016960, Miami 33101, 315-547-6716.

JULY

Vascular and Pulmonary Disease: Diagnosis and Management, July 26-28, Orlando Hyatt, Kissimmee. For information: Stephen Mattingly, 5808 S. Rapp Street, Littleton, CO 80120, (303) 798-9682.



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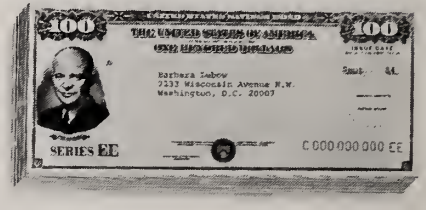


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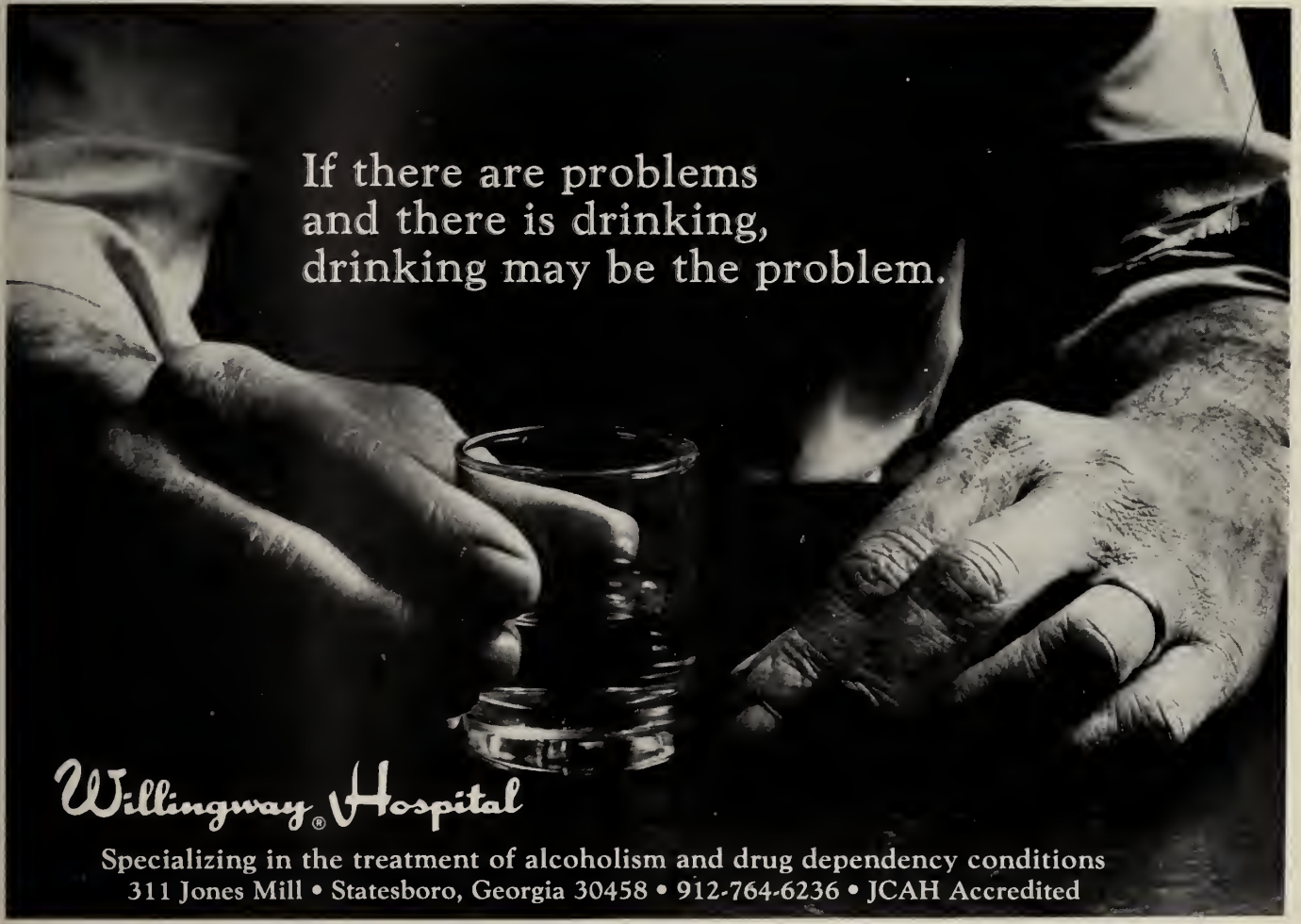


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1. Whiteside, M.E.: Enteric Coccidiosis among patients with the Acquired Immunodeficiency Syndrome. Am. J. Trop Med. Hyg. 33(6) 1984
2. Gourley G. et al: A Rapid Method for Collection and Analysis of Bile Pigments in Humans Gastroenterol, 84(5) 2, 1984
3. Rabbani G.H. et al: Comparison of String-test and Stool Examination in the Diagnosis of Strongyloidiasis and Giardiasis in Gastroenteritis Patients. As. Med. J. 25:695, 1982

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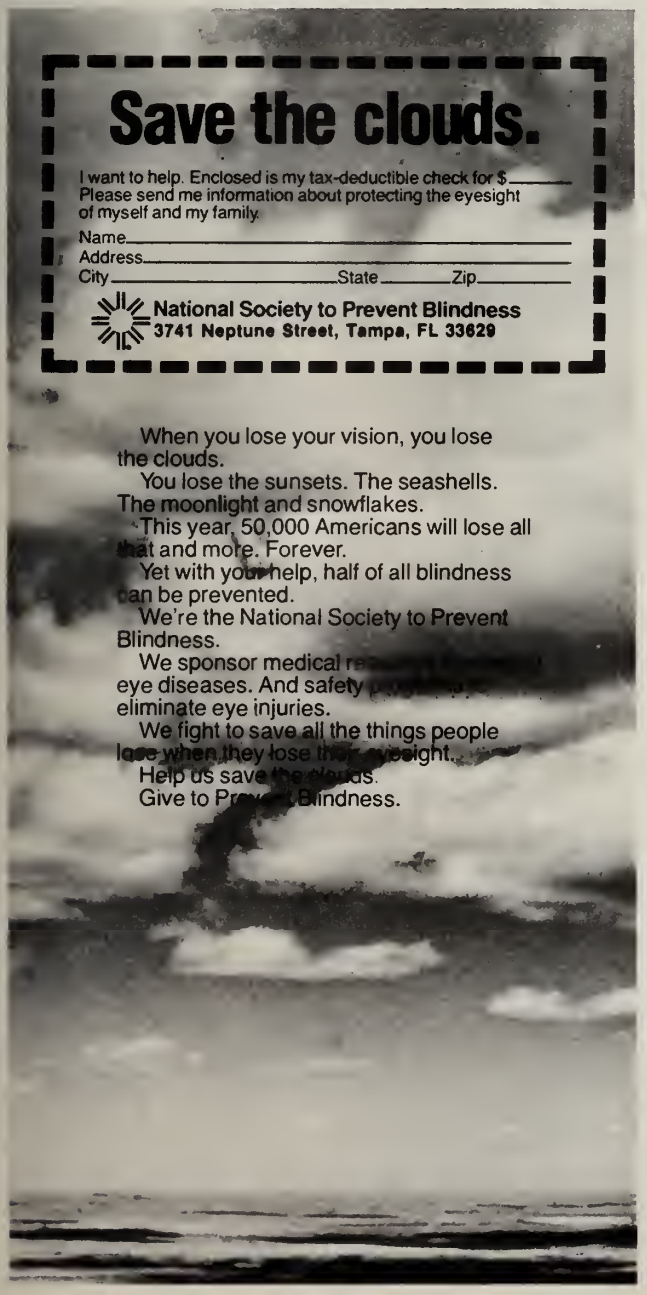
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References: 1. Kales J *et al: Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al: Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al: Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol* 3:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al: Drugs Exp Clin Res 9*(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol* 3:303-326, May 1981. **11.** Greenblatt DJ *et al: Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al: Pharmacology 26*:121-137, 1983.

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Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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THE JOURNAL OF THE
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[redacted]

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Summary of the FMA Board of Governors Meeting March 9, 1985

The following is a summary of the major actions taken by the Board of Governors at its meeting March 9, 1985.

THE BOARD:

FMA Delinquent Dues Assessment

Established May 9, 1985 as the final date for payment of the 1984 special assessment and thereafter any member who has not paid will be dropped from the membership of the Florida Medical Association and his/her respective county medical society.

Informed Consent Law

Affirmed support of FMA efforts in cooperation with the Florida Hospital Association to overturn the Fifth District Court of Appeal decision declaring Florida's informed consent statute unconstitutional.

Medical/Legal Hotline

Approved the establishment of a medical/legal hotline in the FMA Headquarters Office to assist physicians confronted with potential medical/legal difficulties, and further, this program will be evaluated at the end of six months to determine the extent of activity and cost-benefit ratio.

Public Health Public Relations Program

Approved the funding of a public health education program directed at the general public and the medical profession, and further, this program wil be accomplished through the production and distribution of radio and television public service announcements addressing such themes as driving and drinking, use of drugs, automobile safety belts, and smoking, and further, local physicians should be utilized to the greatest possible extent in carrying out these programs.

Impaired Physicians Program Director

Approved the appointment of Roger A. Goetz, M.D., as the Medical Director for the FMA/FMF Impaired Physicians Program.

COMMITTEE ON PROGRAMS AND PRIORITIES

Received a report of the Committee on Programs and Priorities and addressed recommendations from the Executive Committee Report and Recommendations of March 7, 1985.

FMA Communication

Approved the distribution of a single communication to the FMA membership on a monthly basis in lieu of the *FMA Briefs* and *Gray Paper*, subject to evaluation of effectiveness in one year.

Annual Meeting Format

Approved that the Florida Medical Association, Inc. Annual Meeting format be reduced from a five day program (Wednesday to Sunday) to a four day program (Thursday to Sunday), and further, major meetings held in conjunction with the Annual Meeting, such as the Council on Hospital Medical Staffs, be scheduled on Tuesday and Wednesday preceding the First Session of the FMA House of Delegates.

Restructuring of the FMA Board of Governors

Approved the following additional recommended changes in composition of the FMA Board of Governors in addition to those approved at the January 7-8, 1985 meeting:

- That a resident physician whose residency status will not expire before completion of the elected term be elected by the House of Delegates for a term of two years and that such physician have a vote on the Board.
- That a medical student be appointed to the Board by the President for a term of two years beginning at the conclusion of the current medical student term and that this position be rotated consecutively among the

Health Care Financing Administration	Approved the recommendation that the FMA, as much as possible, interrelate with the Federal Health Care Financing Administration, in addition to the State Office of Technical Assistance and other related State and Federal agencies to provide input in the development of health care financing.
DRGs	Approved the recommendation that the Council on Specialty Medicine in concert with FMA's recognized specialty groups document the impact of DRGs on specialty and general practices, and in conjunction with the Subcommittee on Health Care Financing, report to the Board of Governors on a timely basis the impact of DRGs on the practice of medicine.
HMOs	Requested county medical societies to provide the FMA with documented instances of quality of care concerns in respect to HMO health care delivery systems. The Board will also study the development of a form to be used to request from county medical societies instances of concern about poor quality of care rendered by health care delivery systems in Florida.
Medical Assistance Panel	Approved the establishment of a medical assistance panel to advise HRS through input at the policy-making level; and further, for this panel to enhance the capabilities of FMA staff to serve as a resource in working with HRS staff in providing medical input and assistance in the planning, development, and implementation of health programming.
Workers' Compensation	Approved the recommendation that the FMA continue to work with the Office of Medical Services and the three member panel in developing testimony to illustrate the need to increase the reimbursement level to an equitable level of the FEMUR Data Base for 1986. The FMA will submit a letter of protest to the three member panel detailing the dissatisfaction with the small increase in the fee schedule and reiterating some of the testimony that was presented that clearly indicated the need for a more equitable increase.
PRO Activities	The FMA will continue to monitor the activities of the Professional Foundation for Health Care and continue to collect and evaluate any of the problems FMA members encounter with the PRO. The FMA encourages county medical societies and recognized specialty groups to participate in the monitoring process of the Professional Foundation for Health Care and report problems to the FMA PRO Committee; and further, the FMA encourages specialty groups to provide technical assistance and advice pertaining to their individual specialties to the Committee on PRO.
	Requested the Council on Hospital Medical Staffs to monitor the activities of the Professional Foundation for Health Care and also report problems to the PRO Committee for evaluation.
Peer Review for Fee Disputes	The FMA will encourage the AMA to seek legislation to modify the current anti-trust laws to permit resumption of peer review for fee disputes.
Relative Value Studies	Approved the recommendation that the FMA base the 1986 edition of the *Florida Relative Value Studies* on the AMA CPT4 1985 edition.

COUNCIL ON MEDICAL SERVICES

School Entry Exams	Adopted the position of being unalterably opposed to allowing chiropractors and other limited health care practitioners to perform school entry health examinations on the grounds that they are not qualified either by education, training, or experience to perform many of the examinations and make many of the findings that are normally required in a medical examination; and further, that the FMA take whatever steps are appropriate and necessary to assure that only a physician licensed under either Chapter 458 or 459, Florida Statutes, may lawfully perform a health or physical examination upon a child for the purpose of school enrollment in the state of Florida.
Prison Medical Services in Florida	The Florida Medical Association, in conjunction with the Florida Department of Health and Rehabilitative Services (HRS) will propose to the Florida Legislature that funds be provided, through HRS, to the Florida Medical Foundation for: • Evaluation of the current jail medical care system in Florida; • Formulation of recommendations for meeting AMA recognized standards; and • Provision of expertise and an impetus for localities to implement accredited programming.
Fluoridation of Public Water Supplies	Reiterated its support for fluoridation of public water supplies in Florida.
Samuel Rowley, M.D.	Took official notice of the impending retirement of Samuel Rowley, M.D., from the position of Public Health Director of Duval County; and further, the FMA commended Dr. Rowley for the many contributions he has made to public health in that position and as a member of the FMA Committee on Public Health.

COUNCIL ON SPECIALTY MEDICINE

Specialty Group Approval

Placed the following specialty group that has not met all the criteria established by the House of Delegates for recognition by the Association on a one-year probation:

Florida Association of Nuclear Physicians, Inc.

Specialty Group Recognition Approval

Allowed a 60-day grace period beginning February 23, 1985 and ending on April 30, 1985, to the following specialty groups who have a greater than 10% variation in non-FMA members and who are actively recruiting their non-FMA members to join the FMA:

Florida Society of Anesthesiologists
Florida Occupational Medical Association
Council of Florida District Branches of the American Psychiatric Association

Specialty Group Recognition Approval

Approved the continuing recognition for the following specialty groups who have met the criteria established by the House of Delegates for recognition by the Association:

Florida Society of Pathologists
Florida Endocrine Society
Florida Society of Physical Medicine and Rehabilitation

Specialty Group Recognition Criteria

Disapproved a recommendation that the FMA eliminate the requirement in the specialty society recognition program that requires specialty societies to participate in the scientific section of the FMA Annual Meeting once every three years.

Rat Poison

Recommended to the Commissioner of Agriculture that "Blue Ball Rat Poison" and all other similarly dangerous compounds be banned from use or that such compounds be distributed in a tightly controlled manner with appropriate packaging in order to prevent children from ingesting these substances.

Governor's Proclamation

Agreed to notify the Governor of the FMA's concern regarding the proclamation on chiropractors which states "The science of chiropractors and the doctors who practice it have contributed greatly to the better health of our citizenry by providing this specialized health care."

COUNCIL ON SCIENTIFIC ACTIVITIES

Accepted as information the report on final plans for the 111th Annual Meeting Scientific Program.

CME Research Project

Approved FMA participation in the national study being conducted by the Society of Medical College Directors of Continuing Medical Education on CME entitled "Change, Learning, and Education in the Lives of Physicians."

FMA Journal Editor

Commended Daniel B. Nunn, M.D., Editor and Chairman of the Committee on Scientific Publications for his superb contributions and efforts as Editor of the *Journal of the Florida Medical Association* for the past five years and approved the president-elect's selection of Remigio Lacsamana, M.D. as Editor of *The Journal* for the Association year, 1985-1986.

COUNCIL ON HOSPITAL MEDICAL STAFFS

Local County Hospital Medical Staffs Committees

Agreed to encourage county medical societies to establish local county medical society/hospital medical staff committees composed of elected representatives from medical staffs of all hospitals within the county's jurisdiction.

Local County Hospital Medical Staffs

Recommended to county medical societies that each member of the local hospital medical staff committee be an elected member from his/her medical staff serving a two-year term; and further, that he/she be eligible for privileges of the floor in the two Council Hospital Medical Staff statewide meetings held annually.

Slide Presentation

Approved the development of a slide presentation and synchronized narrative to be presented to county medical societies and hospital medical staffs on the purpose and development of the council on hospital medical staffs.

Quarterly Newsletter

The Board approved publication of a quarterly newsletter on hospital medical staff activities to be disseminated to hospital medical staffs and county medical societies.

Risk Management Committee

Approved the establishment of a risk management committee under the purview of the Council on Hospital Medical Staffs for the purpose of developing educational programs to prevent medical malpractice.

COMMITTEE ON MEMBERSHIP DEVELOPMENT

Local Membership Development Committee

All county medical societies are urged to establish committees on membership and development with primary responsibility for membership recruitment and retention; and further, county medical societies are asked to consider appointing to these committees a medical staff representative from each hospital in their area, as well as women physicians and where appropriate, resident physicians and medical student members.

Women in Medicine

The Board authorized a one-day workshop on Leadership Skills for Women Physicians to be held in conjunction with the 1986 FMA Leadership Conference.

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This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

Supplied: 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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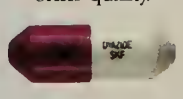
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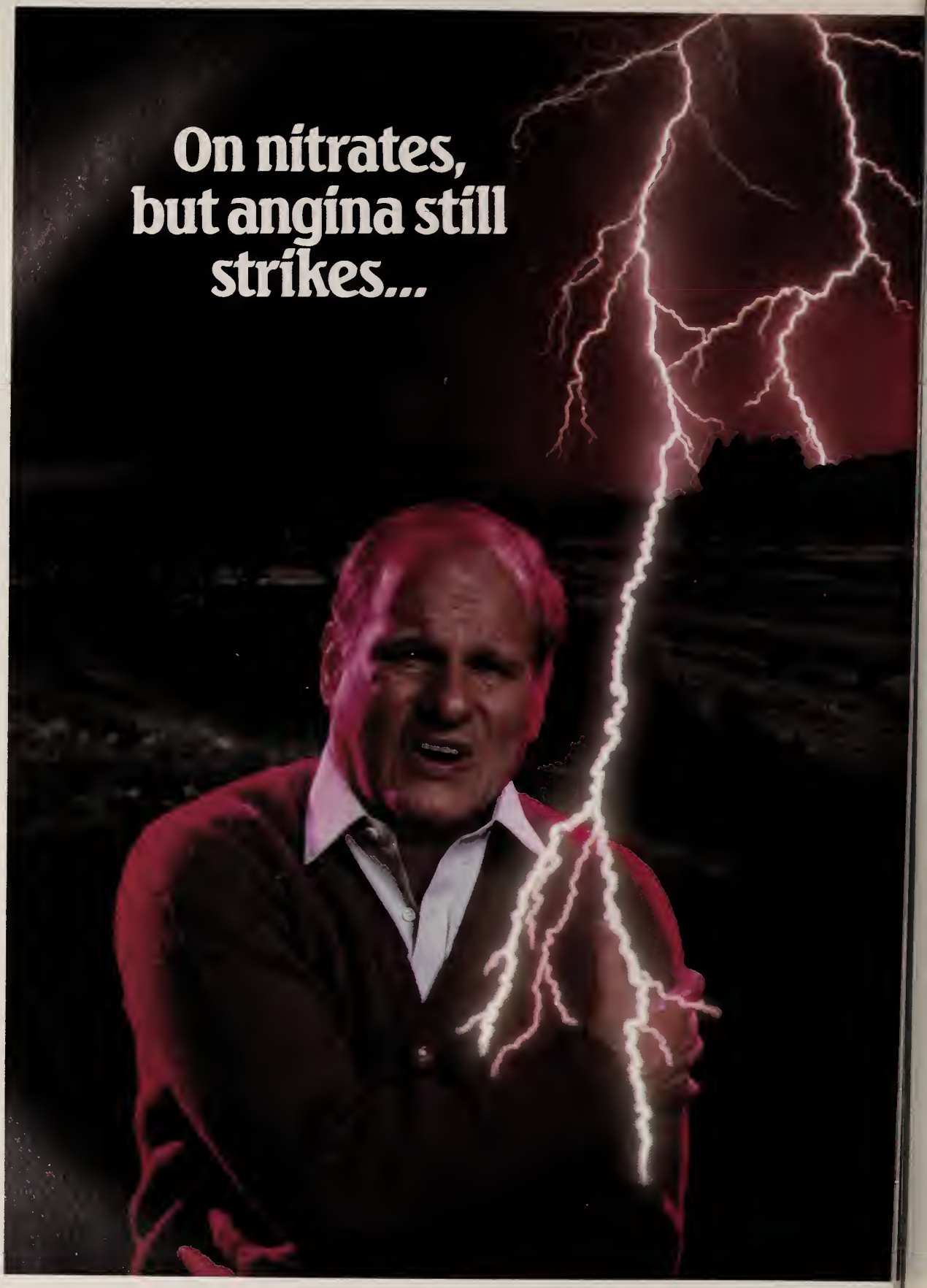


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After a nitrate, add ISOPTIN®
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To protect your patients, as well as their quality of life, add Isoptin instead of a beta blocker.

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Cardiovascular contraindications to the use of Isoptin are similar to those of beta blockers: severe left ventricular dysfunction, hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no artificial pacemaker is present) and second- or third-degree AV block.

So, the next time a nitrate is not enough, add Isoptin...for more comprehensive antianginal protection without side effects which may cramp an active life style.



ISOPTIN. Added antianginal protection without beta-blocker side effects.

Please see brief summary on following page.

ISOPTIN® TABLETS
(verapamil HCl/Knoll)
80 mg and 120 mg

Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure <90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction <30%) or moderate to severe symptoms of cardiac failure. Control milder heart failure with optimum digitalization and/or diuretics before ISOPTIN is used. ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild, and controlled by decrease in ISOPTIN dose). Occasional elevations of liver enzymes have been reported; patients receiving ISOPTIN should have liver enzymes monitored periodically. Patients with atrial flutter/fibrillation and an accessory AV pathway (e.g., W-P-W or L-G-L syndromes) may develop a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion. AV block may occur (3rd degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema, and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with ISOPTIN. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, patients should be monitored closely. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function or in patients who have also recently received methyldopa. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patient carefully monitored. ISOPTIN may have an additive hypotensive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C:* There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR<50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%). The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: confusion, paresthesia, insomnia, somnolence, equilibrium disorders, blurred vision, syncope, muscle cramps, shakiness, claudication, hair loss, maculae, and spotty menstruation. Overall continuation rate of 94.5% in 1,166 patients. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in 80 mg and 120 mg sugar-coated tablets. July 1982 2068

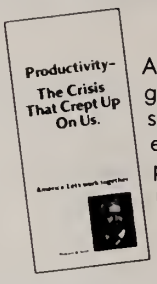
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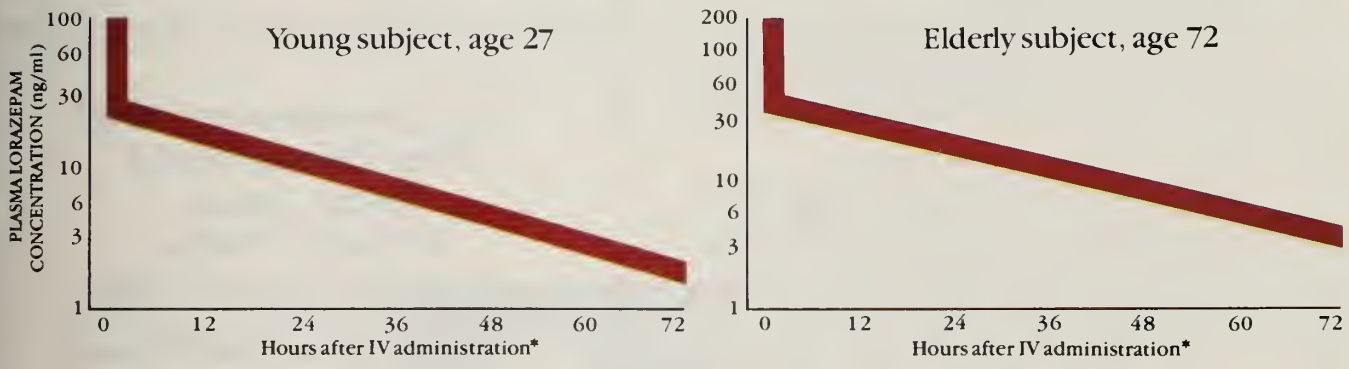
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Among leading benzodiazepines, only Ativan has proof... pharmacokinetics not significantly altered by age.[1]

Representative charts of comparison testing



Lorazepam is nearly 100 percent bioavailable by the intramuscular and oral routes, as compared to the intravenous. Therefore, data for clearance of intravenous lorazepam are equally applicable to oral lorazepam.



- **Clearance not significantly delayed by age, liver or kidney dysfunction**
- **Cumulative sedative effects seldom a problem**
- **Available in 0.5-mg tablets to facilitate the recommended geriatric starting dosage**

1. Greenblatt DJ: Clinical study, pharmacokinetics and bioavailability in the elderly, Ativan® (lorazepam). Data on file, Wyeth Laboratories.

*Fourteen subjects, aged 60 to 84 years, participated in the study. Twelve subjects, aged 19 to 32 years, served as "young controls." Subject dosage was adjusted for body weight and ranged from 1.5 mg to 3.0 mg of lorazepam. Within the study, lorazepam clearance was monitored following IV, IM and oral administration in the elderly group and following IV administration in the control group. The effect of aging on total clearance of lorazepam was relatively small and not statistically significant. Half-life values following the three different routes of administration were essentially identical.

Only Ativan®
(lorazepam)℞

Wyeth Laboratories
Philadelphia, PA 19101

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See important information on following page.



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DISTINCTIVE DESIGN 0.5, 1.0 and 2.0 mg

Brief Summary of Prescribing Information.

Indications and Usage: Management of anxiety disorders or short-term relief of symptoms of anxiety or anxiety associated with depressive symptoms. Anxiety or tension associated with stress of everyday life usually does not require treatment with an anxiolytic.

Effectiveness in long-term use, i.e., more than 4 months, has not been assessed by systematic clinical studies. Reassess periodically usefulness of the drug for the individual patient.

Contraindications: Known sensitivity to benzodiazepines or acute narrow-angle glaucoma.

Warnings: Not recommended in primary depressive disorders or psychoses. As with all CNS-acting drugs, warn patients not to operate machinery or motor vehicles, and of diminished tolerance for alcohol and other CNS depressants.

Physical and Psychological Dependence: Withdrawal symptoms like those noted with barbiturates and alcohol have occurred following abrupt discontinuance of benzodiazepines (including convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Addiction-prone individuals, e.g. drug addicts and alcoholics, should be under careful surveillance when on benzodiazepines because of their predisposition to habituation and dependence. Withdrawal symptoms have also been reported following abrupt discontinuance of benzodiazepines taken continuously at therapeutic levels for several months.

Precautions: In depression accompanying anxiety, consider possibility for suicide.

For elderly or debilitated patients, initial daily dosage should not exceed 2mg to avoid oversedation. Terminate dosage gradually since abrupt withdrawal of any antianxiety agent may result in symptoms like those being treated: anxiety, agitation, irritability, tension, insomnia and occasional convulsions. Observe usual precautions with impaired renal or hepatic function. Where gastrointestinal or cardiovascular disorders coexist with anxiety, note that lorazepam has not been shown of significant benefit in treating gastrointestinal or cardiovascular component. Esophageal dilation occurred in rats treated with lorazepam for more than 1 year at 6mg/kg/day. No effect dose was 1.25mg/kg/day (about 6 times maximum human therapeutic dose of 10mg/day). Effect was reversible only when treatment was withdrawn within 2 months of first observation. Clinical significance is unknown; but use of lorazepam for prolonged periods and in geriatrics requires caution and frequent monitoring for symptoms of upper G.I. disease. Safety and effectiveness in children under 12 years have not been established.

ESSENTIAL LABORATORY TESTS: Some patients have developed leukopenia, some have had elevations of LDH. As with other benzodiazepines, periodic blood counts and liver function tests are recommended during long-term therapy.

CLINICALLY SIGNIFICANT DRUG INTERACTIONS: Benzodiazepines produce CNS depressant effects when administered with such medications as barbiturates or alcohol.

CARCINOGENESIS AND MUTAGENESIS: No evidence of carcinogenic potential emerged in rats during an 18-month study. No studies regarding mutagenesis have been performed.

PREGNANCY: Reproductive studies were performed in mice, rats, and 2 strains of rabbits. Occasional anomalies (reduction of tarsals, tibia, metatarsals, malrotated limbs, gastroschisis, malformed skull and microphthalmia) were seen in drug-treated rabbits without relationship to dosage. Although all these anomalies were not present in the concurrent control group, they have been reported to occur randomly in historical controls. At 40mg/kg and higher, there was evidence of fetal resorption and increased fetal loss in rabbits which was not seen at lower doses. Clinical significance of these findings is not known. However, increased risk of congenital malformations associated with use of minor tranquilizers (chlordiazepoxide, diazepam and meprobamate) during first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, use of lorazepam during this period should almost always be avoided. Possibility that a woman of child-bearing potential may be pregnant at institution of therapy should be considered. Advise patients if they become pregnant to communicate with their physician about desirability of discontinuing the drug. In humans, blood levels from umbilical cord blood indicate placental transfer of lorazepam and its glucuronide.

NURSING MOTHERS: It is not known if oral lorazepam is excreted in human milk like other benzodiazepines. As a general rule, nursing should not be undertaken while on a drug since many drugs are excreted in milk.

Adverse Reactions, if they occur, are usually observed at beginning of therapy and generally disappear on continued medication or on decreasing dose. In a sample of about 3,500 anxious patients, most frequent adverse reaction is sedation (15.9%), followed by dizziness (6.9%), weakness (4.2%) and unsteadiness (3.4%). Less frequent are disorientation, depression, nausea, change in appetite, headache, sleep disturbance, agitation, dermatological symptoms, eye function disturbance, various gastrointestinal symptoms and autonomic manifestations. Incidence of sedation and unsteadiness increased with age. Small decreases in blood pressure have been noted but are not clinically significant, probably being related to relief of anxiety.

Transient amnesia or memory impairment has been reported in association with the use of benzodiazepines.

Overdosage: In management of overdosage with any drug, bear in mind multiple agents may have been taken. Manifestations of overdosage include somnolence, confusion and coma. Induce vomiting and/or undertake gastric lavage followed by general supportive care, monitoring vital signs and close observation. Hypotension, though unlikely, usually may be controlled with Levarterenol Bitartrate Injection U.S.P. Usefulness of dialysis has not been determined.

Ativan® (IV) **for** (lorazepam) **Anxiety**

DOSAGE: Individualize for maximum beneficial effects. Increase dose gradually when needed, giving higher evening dose before increasing daytime doses. Anxiety, usually 2-3mg/day given b.i.d. or t.i.d.; dosage may vary from 1 to 10mg/day in divided doses. For elderly or debilitated, initially 1-2mg/day; insomnia due to anxiety or transient situational stress, 2-4mg h.s.

HOW SUPPLIED: 0.5, 1.0 and 2.0mg tablets.

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The graying of America



This Special Issue of *The Journal*, which is being published under the sponsorship of the Auxiliary to the Florida Medical Association, is both timely and important, and represents a major contribution to the continuing education of the members of FMA. The practice of geriatric medicine is different in many ways from that of medicine provided to younger age groups.

The demographics of our Florida population bring us face to face with the fact that between now and the year 2000, only 15 years from now, the population of Florida is expected to grow by 63%. In actual numbers, this means that the population in Florida by the year 2000 will have increased from the current 10,680,000 to 17,438,000.

Presently, eighteen percent of our population is over the age of 65. By the year 2000, this will have increased to at least 20%. Therefore, in fifteen years Florida will have 3,480,000 people over the age of 65. People over the age of 65 consume three and a half times as many health services as those in younger age groups. Days of hospitalization for people over 65 are four times that of younger people, and physicians' services are used three times more frequently. The elderly purchase three times as many drugs as younger people.

Life expectancy of the elderly continues to increase and death rates are declining. By the year 2000, 45% of the people over age 65 will be, in fact, over 75. Decreasing death rates among the elderly are related to a dramatic decline in death rates from heart disease and stroke. Cancer is the only major cause of death that is increasing.

As life expectancy at birth increases, and death rates among the elderly continue to decline, it will not be unusual to see people over the age of 100.

As the age of the population increases, the demand for health services increases. Patients over the age of 85 utilize health services eight times more frequently than those under age 65.

With this aging population and its requirements for increased health services, what will be the impact upon hospitals and physicians? It is anticipated that there will be an almost 30% increase in the need for hospital beds. A recent report from the Post Secondary Education Planning Commission on Medical Education in Florida states that Florida now has approximately 20,000 physicians in active practice. Projections for the need in the year 2000 would be in the vicinity of 29,000 physicians. Medical schools in Florida are currently graduating 343 physicians annually. Fourteen hundred physicians, however, are being licensed each year. Thus, we have an in-migration of substantial numbers of physicians. It would appear, therefore, that we will have enough physicians in the year 2000 to meet the needs of our people.

The increasing attention to the need for nursing home beds suggests that a large number of additional nursing home beds will be required, and much more extensive home health care programs will be required. One very significant statistic about the elderly population suggests that at age 85 elderly women far outnumber elderly men. At this age, there will be 42 men for every 100 women.

How do the Florida statistics compare with those nationally? The people over age 65 now com-

prise approximately 11% of the population nationally. By the year 2000, this is expected to increase to 16%.

By the year 2000, there will be one elderly person on Social Security and Medicare for every three workers. Twenty-five years later, because of the decreasing birth rate and decreasing death rate of the elderly, this number will have dropped to one retiree for every two workers. The implications of these changes in the demographics of our society for Medicare, Social Security, and our health care delivery system are enormous. Because of concerns relative to aging, a Governor's Committee on Aging was formed in early 1984 to examine the "state of aging" in Florida. This committee submitted a report in January 1985 which highlights the demographics of aging but does not address in-depth the special problems of aging or solutions for dealing with these problems.

Much more extensive studies will be required, and these should be undertaken immediately. Some of the questions that must be answered include the following:

How can society fund the needed health care for the elderly?

How can stay-well programs for the elderly be developed?

How can we deal with the ethical problems related to terminal illness?

How should we use medical technology that might not be lifesaving but will improve, at least for a time, the quality of life?

How will we deal with mental and psychiatric problems, such as Alzheimer's disease, which occur with increasing frequency as people age?

What special skills must physicians acquire so that they can practice geriatric medicine effectively?

The answers to these and many other questions related to health care for the elderly must be found soon.

Frank C. Coleman MD

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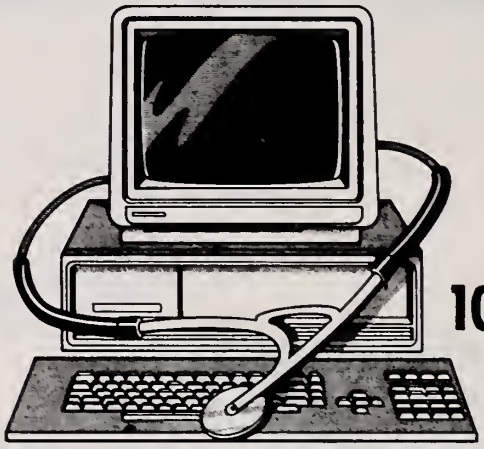
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EDITORIAL

Aging: medicine's new frontier

Florida is the state with the highest proportion of elderly in the United States. This constitutes a geographic and demographic imperative for Florida physicians to excel in understanding the health problems of the aging and in delivering health services to our aging citizens. In fact, in some of our coastal cities and in some retirement communities the elderly make up the majority of health care seekers, and many physicians and not a few hospitals are experiencing "wall-to-wall" elderly. We therefore have here in Florida a special opportunity and a special responsibility to be especially Knowledgeable and skilled in matters related to the health and well-being of aging persons.

Each of the state's three medical schools, alone and in colloboration with their affiliated VA Hospitals, has already established substantial progress in education, research, and direct services to the elderly. The Florida Medical Association has given increasing recognition and visibility to this emerging area, through the creation of an FMA Committee on Aging, the presentation of a special symposium on the process of aging at the 1982 FMA Meeting and the sponsorship this year by the FMA Committee on Aging of a special symposium on "The Care of the Aging Patient". Further, this Special Issue of *The Journal of the Florida Medical Association* is devoted to issues in health care of the aging, with the welcome involvement and support of the Florida Medical Association Auxiliary.

But it is the individual physician who can have the greatest impact on the health and well-being of our aging citizens. It is with him and her that I would like to share some basic principles of working successfully with aging patients, gleaned from nearly twenty years of practice with elderly patients. These principles are not specific to any given medical specialty or subspecialty but apply across the board. These principles are as follows:

1. Older patients are indeed responsive to treatment, so long as the approach to diagnosis and treatment takes into consideration the changed psychosocial and physiological circumstances.
2. The great majority of elderly are well and not ill, but those elderly who do become ill often require multidisciplinary intervention to restore them to normal functioning.
3. Older patients should be evaluated not only along diagnostic lines but also along functional lines including assessment of their physical and mental functioning, their social and financial resources and their self-care capacity, regardless of the specific medical intervention contemplated.
4. Older persons often require someone to coordinate all their needed services; sometimes this is referred to as case management.
5. Family members of aging patients are vital in both providing information about the patient and in carrying out a treatment plan.
6. Care of the aging patient requires special skills, knowledge and attitudes, and physicians who did not receive formal training in geriatrics in medical school should avail themselves of every opportunity to acquire special gerontological and geriatric expertise.
7. Not only are older patients treatable; they are also teachable. They can certainly learn to understand those factors which influence their specific illness both positively and negatively.

8. Finally, older patients can also teach us as physicians about the health care experience of an older person, thus supplementing our formal and scientific understanding of the aging process.

These basic principles of working with the elderly, coupled with new scientific advances in understanding aging, will make health care of the elderly the new frontier in medicine. The benefits of investing energy and effort in advancing the level of health care of the elderly are not inconsiderable. Not only will our aging patients benefit, but we ourselves may well be the beneficiaries of these advances; for we are all, after all, aging.

Eric Pfeiffer, M.D.
Tampa



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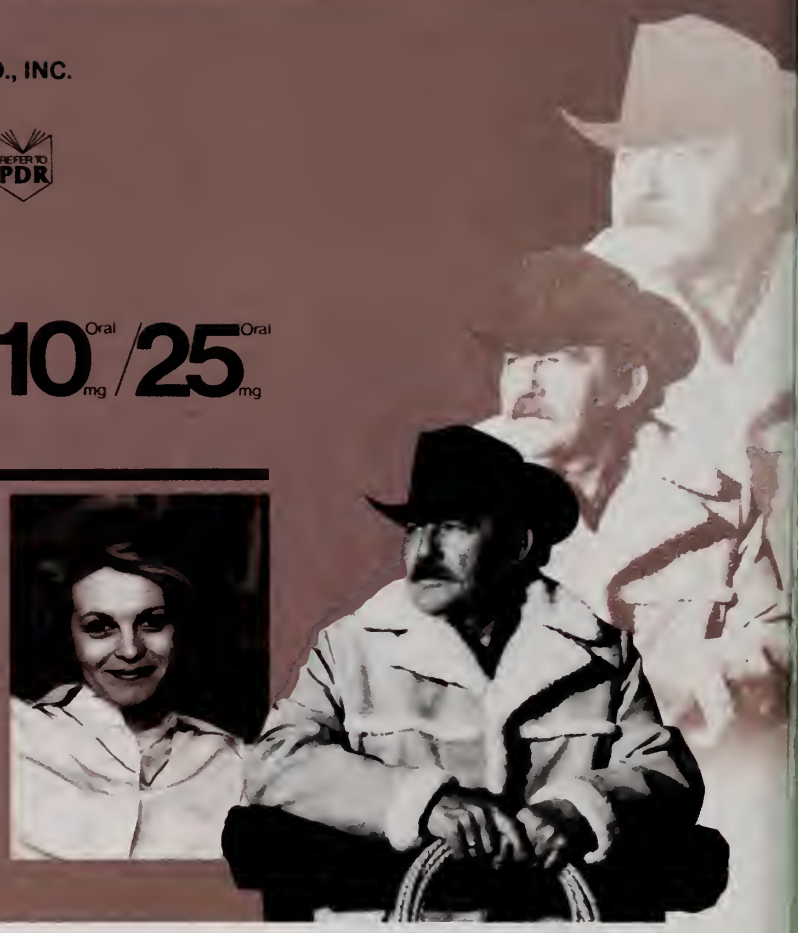
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FMF IMPAIRED PHYSICIANS COMMITTEE NEWSLETTER

Published by the Committee on Impaired Physicians / Florida Medical Foundation / P. O. Box 2411 / Jacksonville, Florida 32203

April 1985 "Doctors Helping Doctors" Vol. 2 — No. 2

Program Complete for Annual Meeting Section

The program is complete for the 5th Annual Section on Chemical Dependency, to be presented on Thursday, May 2, during the FMA Annual Meeting at the Diplomat in Hollywood.

Four physicians and an attorney will participate in a panel on "Medico-Legal Implications of Physician Substance Abuse." Moderator will be E. Joan Barice, M.D., of Palm Beach Gardens, President of the Florida Chapter of the American Medical Society on Alcoholism.

Physician panelists will include: Roger A. Goetz, M.D., of Fernandina Beach, newly-appointed Medical Director of the IPP; Dolores A. Morgan, M.D., of Miami; and Richard J. Feinstein, M.D., of Miami, Immediate Past President of the Florida Board of Medical Examiners. They will be joined by Deborah J. Miller, J.D., of Miami, former Assistant General

(Continues on Next Page)

Search for Medical Director Ends; Dr. Roger A. Goetz Is Appointed

Roger A. Goetz, M.D., an anesthesiologist with extensive experience in the treatment and management of addictive diseases, has become the first full-time medical director of the FMA-FMF Impaired Physicians Program.

Dr. Goetz and the IPP agreed to terms of a three-year contract on February 7, ending a medical director search that had lasted for more than a year, according to Guy T. Selander, M.D., Chairman of the Committee on Impaired Physicians.

Dr. Goetz, 50, comes to Florida from Columbia, SC, where he was corporate director of medical affairs for a large company. While in South Carolina, Dr. Goetz was Chairman of the Treatment Management Team and a member of the Impaired Physicians Committee of the Medical Society of South Carolina. He has been active in intervention, detoxification and treatment of impaired physicians for the past five years.

A native of Milwaukee, Wisc., Dr. Goetz received his medical degree from Marquette University School of Medicine. He is certified by the American Board of Anesthesiology and is a member of many medical organizations, including the American Academy of Addictionology, of which he is a director. He has held teaching appointments at Marquette and the University of Illinois School of Medicine.

"We are most fortunate in being able to attract a professional of Dr. Goetz's caliber and background," Dr. Selander commented. "We are very grateful to Dr. Dolores Morgan for agreeing to take on this job in addition to all her other jobs back in 1980. Without her, we would be miles short of where we are today."

Dr. Morgan, a Miami addictionologist who served as part-time medical director of the IPP since the beginning, did not apply for the full-time appointment.

With the appointment of Dr. Goetz, FMA becomes the second state medical association to retain a full-time medical director for its impaired physicians program. New Jersey was first in 1982.

(Continues on Next Page)

Macdonald Renamed ADAMHA Director

The Reagan Administration has resubmitted to the Senate the nomination of Donald I. Macdonald, M.D., of Clearwater as administrator of the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA).

Dr. Mcdonald, former Chairman of the FMA Committee on Substance Abuse and a pediatrician, has held the federal post since last summer. The nomination will be taken up by the Senate Labor and Human Resources Committee, chaired by Sen. Orin Hatch (R-Utah). A hearing is not necessary for Senate confirmation.



Guy T. Selander, M.D. (left), Chairman of the Committee on Impaired Physicians, congratulates Roger A. Goetz, M.D., on his appointment as the IPP's first full-time Medical Director. For the time being, Dr. and Mrs. Goetz will reside at Fernandina Beach, and he will work out of Jacksonville.

Search (Con't)

Commenting on his new position, Dr. Goetz said:

"I am extremely enthusiastic about continuing my involvement in the addiction field in this particular state and in this particular program. Dr. Selander and Dr. Morgan have been involved with the program only part-time, but they have done wonders. I hope to build on the firm foundation that they have laid down."

Dr. Selander said Dr. Goetz will be working to refine and expand the IPP, which has admitted, treated and in most cases rehabilitated about 200 alcoholic and drug-addicted physicians, osteopaths, dentists, pharmacists, veterinarians and others. Duties also will include working with the Florida Board of Medical Examiners, other professional groups and local impaired physicians committees. He will form intervention teams, develop educational programs and standards for treatment facility accreditation, and supervise after-care and follow-up.

Dr. Goetz will maintain his office in Jacksonville. He and his wife, Mrs. Kay Orr-Goetz, will reside temporarily at Fernandina Beach.

Program (Con't)

Counsel of the Department of Professional Regulation and now a private attorney specializing in professional licensure disciplinary matters.

Charles V. Wetli, M.D., Deputy Chief Medical Examiner of Dade County, will present a paper on "Update Cocaine: A Continuing Craze of the '80's."

The program will begin at 1:00 p.m. and adjourn at 4:00 p.m. It has been approved for three hours of AMA Category I and AAFP Prescribed CME credit.

Arvey I. Rogers, M.D., of Miami, and Dr. Barice are in charge of the program.

CMA Develops Guides for Hospital Monitoring

The California Medical Association has developed guidelines for monitoring recovering physicians in the hospital medical staff setting. Information may be obtained by contacting Ms. Gail Jara, California Medical Association, 44 Gough Street, San Francisco, CA 94103, (415) 863-5522.

Board of Medical Examiners Has Its Own IP Telephone 'Hot Line'

The Florida Board of Medical Examiners has been distributing posters and pamphlets suggesting that impaired physicians can be referred for treatment by calling a Miami area telephone number.

According to the publications, "A call to the number listed below will reach a physician/consultant for the Florida Board of Medical Examiners who will refer the impaired physician to an appropriate, approved treatment program. The public will be protected, confidentiality maintained and the ill physician will receive needed treatment."

The number given is (305) 325-9175.

This is not the FMA-FMF Impaired Physicians Program hot line number. The number for the FMA-FMF program is (305) 531-2185.

The FMA-FMF number rings into the office of Dolores A. Morgan, M.D., at Mt. Sinai Medical Center at Miami Beach. Dr. Morgan is the former Medical Director of the IPP. The hot line will be relocated when the new Medical Director, Roger A. Goetz, M.D., moves into permanent offices.

Although the public and private sectors at the present time have separate "hot lines," the FMA-FMF Impaired Physicians Program continues to cooperate fully with the Board of Medical Examiners.

Office Address and Telephone Number For Medical Director

As this issue of the *IP Newsletter* went to press, IP Medical Director Roger A. Goetz, M.D., established his office at:

Suite 621
Broadview Executive Center
1000 Riverside Avenue
Jacksonville, FL 32204

The office telephone number is (904) 354-3397, and that number should be used to communicate with Dr. Goetz and to report impaired physicians. After office hours calls will be automatically call-forwarded to his residence.

Mail should be addressed to:
Roger A. Goetz, M.D.,
Medical Director
FMA-FMF Impaired Physicians Program
P. O. Box 2411
Jacksonville, FL 32203

Dr. Goetz to Address State Bar Convention

Roger A. Goetz, M.D., IPP Medical Director, will discuss professional impairment in an address to the Florida Bar at its Annual Meeting in Boca Raton on June 27.

Dr. Goetz has been having discussions with Attorney Charles Hagan, Substance Abuse Coordinator of the Florida Bar. "We are going to try to help the Bar by providing back-up and support systems," Dr. Goetz said.

Marion Co. Physicians Hear IP Presentation

Guy T. Selander, M.D., Chairman of the IP Committee, addressed the Executive Committee and Committee on Impaired Physicians of the Marion County Medical Society in Ocala on January 22.

Bowling Green Inn gets IP Committee Approval

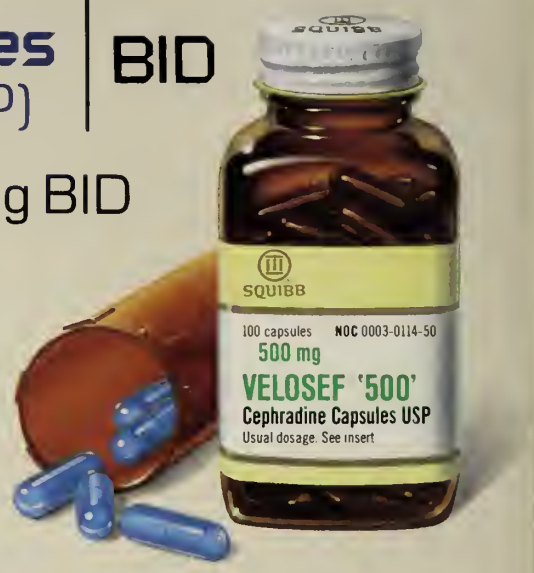
Bowling Green Inn of Bowling Green, Fla., has been approved as a treatment facility to admit patients in the FMA-FMF Impaired Physicians Program. The period of approval is two years, ending January 31, 1987.

Other approved programs in Florida include: South Miami Hospital, Miami; Mt. Sinai Medical Center, Miami Beach; Lakeland Regional Medical Center; Palm Beach Institute, West Palm Beach; and Horizon Hospital, Clearwater.

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Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

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Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Hematologic — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structure infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h). For dosage recommendations in patients with impaired renal function, consult package insert.

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

For full prescribing information, consult package insert.

HOW SUPPLIED: 250 mg and 500 mg capsules in bottles of 24 and 100 and Unimatic® unit-dose packs of 100. 125 mg and 250 mg for oral suspension in bottles of 100 ml and 200 ml.

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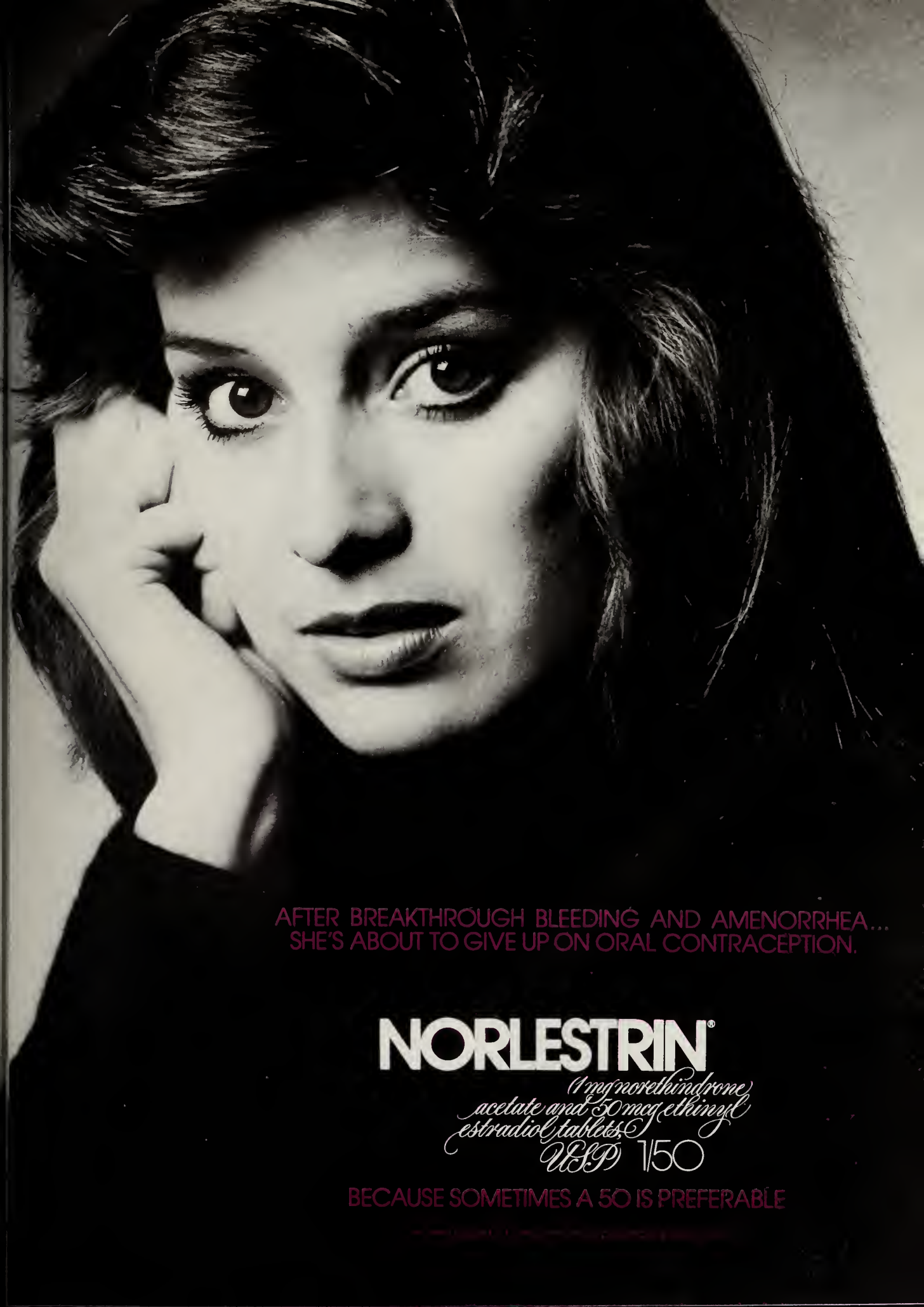
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NORLESTRIN®
1 mg norethindrone acetate and 50 mcg ethinyl estradiol tablets, USP 1/50
BECAUSE SOMETIMES A 50 IS PREFERABLE

Brief Summary of Prescribing Information
NORLESTRIN® (norethindrone acetate and ethinyl estradiol tablets, USP)

See section under **Special Notes on Administration and HOW SUPPLIED.**
Before prescribing, please see full prescribing information. A Brief Summary follows.

DESCRIPTION
Norlestrin Products are progestogen-estrogen combinations.

INDICATIONS AND USAGE
Norlestrin Products are indicated for the prevention of pregnancy in women who elect to use oral contraceptives as a method of contraception

In clinical trials with Norlestrin 1/50 involving 25,983 therapy cycles, there was a pregnancy rate of 0.05 per 100 woman-years; in clinical trials with Norlestrin 2.5/50 involving 96,388 cycles, there was a pregnancy rate of 0.22 per 100 woman-years

Dose-Related Risk of Thromboembolism from Oral Contraceptives: Studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. It is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance

CONTRAINDICATIONS
1. Thrombophlebitis or thromboembolic disorders
2. A past history of deep-vein thrombophlebitis or thromboembolic disorders
3. Cerebral vascular or coronary artery disease
4. Known or suspected carcinoma of the breast
5. Known or suspected estrogen-dependent neoplasia
6. Undiagnosed abnormal genital bleeding
7. Known or suspected pregnancy (See WARNING No. 5)
8. Benign or malignant liver tumor which developed during the use of oral contraceptives or other estrogen-containing products

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. The risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. *Thromboembolic Disorders and Other Vascular Problems.* An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well-established. Studies have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic.

Cerebrovascular Disorders: In a collaborative study in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than nonusers, and the risk of thrombotic stroke was 4.0 to 9.5 times greater.

Myocardial Infarction: An increased risk of myocardial infarction associated with oral contraceptives has been reported confirming a previously suspected association. These studies found that the greater the number of underlying risk factors (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia) for coronary artery disease, the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor.

It has been estimated that users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are smokers have about a fivefold increased risk of fatal infarction compared to users who do not smoke, but about a tenfold to twelvefold increased risk compared to nonusers who do not smoke. The amount of smoking is also an important factor.

Risk of Dose: In an analysis of data, British investigators concluded that the risk of thromboembolism, including coronary thrombosis, is directly related to the dose of estrogen used in oral contraceptives, however, the quantity of estrogen may not be the sole factor involved.

Persistence of Risk: Two studies have suggested that an increased risk may persist for as long as 6 years after discontinuation of oral contraceptive use for cerebrovascular disease and 9 years for myocardial infarction. In addition, a prospective study suggested the persistence of risk for subarachnoid hemorrhage.

Estimate of Excess Mortality from Circulatory Diseases: The risk of diseases of the circulatory system is concentrated in older women, in those with a long duration of use, and in cigarette smokers.

A study of available data from a variety of sources concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke.

The risk of thromboembolic and thrombotic diseases associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia, and especially by cigarette smoking.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders. Should any occur or be suspected, the drug should be discontinued immediately.

A fourfold to sixfold increased risk of postsurgery thromboembolic complications has been reported in users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization.

2. *Ocular Lesions.* Neuro-ocular lesions, such as optic neuritis or retinal thrombosis, have been associated with the use of oral contraceptives. Discontinue the oral contraceptive if there is unexplained sudden or gradual, partial, or complete loss of vision; onset of proptosis or diplopia; papilledema; or retinal vascular lesions.

3. *Carcinoma.* Long-term continuous administration of estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver.

In humans, an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women has been reported. However, there is no evidence suggesting increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives.

Studies found no evidence of increase in breast cancer in women taking oral contraceptives, however, an excess risk in users with documented benign breast disease was reported.

There is no confirmed evidence of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of users is, nevertheless, essential. In cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer, or who have breast nodules, fibrocystic disease, or abnormal mammograms, should be monitored with particular care.

4. *Hepatic Tumors.* Benign hepatic adenomas have been found to be associated with oral contraceptives. Because hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage, they should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time.

5. *Usage in or Immediately Preceding Pregnancy, Birth Defects in Offspring, and Malignancy in Female Offspring.* During early pregnancy, female sex hormones may seriously damage the offspring.

An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of oral contraceptives in pregnancy.

There is some evidence that triploidy and possible other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives.

Pregnancy should be ruled out before continuing an oral contraceptive in any patient who has missed two consecutive menstrual periods. If the patient has not adhered to the schedule, the possibility of pregnancy should be considered at the time of the first missed period, and oral contraceptives should be withheld until pregnancy has been ruled out. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed.

Women who discontinue oral contraceptives with the intent of becoming pregnant should use an alternate form of contraception for a period of time before attempting to conceive.

Administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. *Gallbladder Disease.* Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives.

7. *Carbohydrate and Lipid Metabolic Effects.* Because decreased glucose tolerance has been observed in a significant percentage of patients, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed.

8. *Elevated Blood Pressure.* An increase in blood pressure has been reported in patients receiving oral contraceptives. The prevalence in users increases with longer exposure. Age is also strongly correlated with development of hypertension. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure.

9. *Headache.* Onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives.

10. *Bleeding Irregularities.* Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, nonfunctional causes should be borne in mind. In undiagnosed abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy.

Women with a past history of oligomenorrhea or secondary amenorrhea, or young women without regular cycles should be advised that they may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives.

11. *Ectopic Pregnancy.* Ectopic as well as intrauterine pregnancy may occur in contraceptive failures.

12. *Breast-Feeding.* Oral contraceptives may interfere with lactation. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs.

PRECAUTIONS

1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another examination.
2. Preexisting uterine leiomyomata may increase in size.
3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree.
4. Oral contraceptives may cause fluid retention and should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated.
5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice. If jaundice develops, the medication should be discontinued.
6. Steroid hormones may be poorly metabolized and should be administered with caution in patients with impaired liver function.
7. Users may have disturbances in normal tryptophan metabolism, which may result in a relative pyridoxine deficiency.
8. Serum folate levels may be depressed.
9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted.
10. Certain endocrine and liver function tests and blood components may be affected: (a) Increased sulfobromophthalein retention. (b) Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. (c) Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone. (d) Decreased pregnanediol excretion. (e) Reduced response to metyrapone test.

Drug Interactions: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, tetracycline, and ampicillin.

ADVERSE REACTIONS
An increased risk of the following serious adverse reactions has been associated with oral contraceptives: thrombophlebitis, pulmonary embolism; coronary thrombosis, cerebral thrombosis, cerebral hemorrhage, hypertension; gallbladder disease, benign hepatomas, congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: mesenteric thrombosis, neuro-ocular lesions, eg, retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related: nausea and/or vomiting, usually the most common adverse reactions, occur in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally: gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea, amenorrhea during and after treatment, temporary infertility after discontinuance of treatment, edema, chloasma or melasma, breast changes, change in weight, change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum, cholestatic jaundice, migraine, increase in size of uterine leiomyomata, rash (allergic); mental depression, reduced tolerance to carbohydrates, vaginal candidiasis, change in corneal curvature, intolerance to contact lenses.

The following adverse reactions have been reported and the association has been neither confirmed nor refuted: premenstrual-like syndrome; cataracts; changes in libido, chorea, changes in appetite, cystitis-like syndrome; headache; nervousness, dizziness, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum; hemorrhagic eruption, vaginitis, porphyria.

Special Notes on Administration
Menstruation usually begins two or three days, but may begin as late as the fourth or fifth day, after discontinuing medication.

After several months on treatment, bleeding may be reduced to a point of virtual absence, reduced flow may be a result of medication and not indicative of pregnancy.

HOW SUPPLIED
Norlestrin [21] 1/50 is available in compacts each containing 21 tablets. Each tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin [21] 2.5/50 is available in compacts each containing 21 tablets. Each tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin [Fe] 1/50 is available in compacts each containing 21 yellow tablets and 7 brown tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin [FE] 2.5/50 is available in compacts each containing 21 pink tablets and 7 brown tablets. Each pink tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin [28] 1/50 is available in compacts each containing 21 yellow tablets and 7 white inert tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

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Auxiliary Special Issue on Aging



The Auxiliary and the FMA are producing this Special Auxiliary Issue of *The Journal.* This is the fourth of such issues which began with highlights of Auxiliary activities in 1982, while 1983 carried the theme of Learning Disabilities, and 1984 featured Substance Abuse. The theme for this year's issue is The Aging Process with an emphasis on the Positive Aspects of Aging, a topic in which both organizations have a vital interest.

Aging is of fundamental concern to physicians in the state of Florida because Florida has a greater number of persons over age 60 than any other state in the nation. Adele Graham, wife of Governor Bob Graham, and Virginia Essex both point this out in their articles. Also, the percent of the population over 60 is greater here than elsewhere. This segment of the population brings many benefits and contributions to the state as well as many problems. These people represent a vast reservoir of knowledge, talent and experience. (See Harold Sheppard's article, "Population Aging as Progress, Not a Burden"). Since the population in the nation as a whole is growing older, Florida currently has both problems and benefits which other states will have in the future. This gives us an opportunity to develop innovative programs and to be leaders and trendsetters.

Physicians, hopefully, will be at the forefront of this movement. Because of their numerous contacts with the elderly and their families, physicians have many opportunities to help change public opinion on the subject of aging and to help change patients' ideas and attitudes toward themselves as they age.

Many of the myths about the elderly which abound in our society are inaccurate and damaging. These myths are mentioned by Doctors Scheinberg, Cohen and Eisdorfer in their article appearing in Worth Repeating "Employing the Older Worker." The myths are damaging not only because they are so readily accepted by our youth-oriented society but, as the authors point out, because the elderly begin to believe them about themselves!

In addition to the strictly scientific articles on the aging process, we have included articles on perceptive and thoughtful programs dealing with the elderly which we hope physicians will find useful. Carolee DeVito tells of a hospital-centered long-term care program in Miami Beach. Clayton Hansen outlines a program of health education for seniors. Dr. George Caranasos gives excellent guidelines for developing a course for "caregivers" of the demented elderly, a much needed program.

We felt doctors might appreciate knowing about the opportunities for healthy mental activities for senior citizens, such as attending state institutions of higher learning with tuition waived, and traveling via Elderhostel which are detailed in the article by Virginia Elgin. The benefits offered by volunteering in the community, for and by the aging, are pointed out by Virginia Essex. Anne Swing mentions the importance of explaining medications carefully to aging patients and points out how the Medi-File card, printed by the FMA and FMA-A, can help.

It has been a pleasure to work with the authors, the cover artist, and *The Journal* staff. I have learned a great deal myself, as one always does when one takes on a volunteer job. We hope the physicians of Florida will find this Special Issue on Aging helpful to them as they deal with the geometrically increasing numbers of "old folks" in Florida.

Mrs. L.G. (Mae) White
Guest Editor
Fort Lauderdale

Remarks from Mrs. Adele Graham



This is an exciting period to be involved in advocacy work for older people. Because Florida has more citizens over 60 than any other state, we are dealing with aging issues now that other states will not have to address for years to come. This means the nation is watching how we deal with the problems and take advantage of the opportunities brought to us by our older population.

I am proud of the example Florida is setting. We are developing sensitive, responsible policies and building innovative effective programs. We recognize our older population as a wealth of knowledge and talent and energy that gives back more than it takes from the state. We are utilizing the combined strength of both public and private sectors as well as nonprofit organizations such as the Florida Medical Association Auxiliary to support our aging programs and to keep our momentum going.

Momentum is important. We are doing a lot for Florida's older citizens but there is much more to be done. We must continue to search for solutions and plan to for the future. That is why my husband, Bob, assembled the Florida Committee on Aging last June. He charged this 20-member group, chaired by former Senate President Phil Lewis, to draw up a blueprint for developing services and strategies on aging issues that our state can follow now and in the years to come. The committee submitted its report in January. The report provides guidelines that not only will lead Florida in the right direction but will point the way for other states when the time comes for them to deal with aging issues.

To me, this report reinforces for fact that Florida is committed to doing its utmost for our older people. I have seen this same commitment in the programs developed and carried out by the state's Aging and Adult Services Program Office.

One program in which I am personally involved is Community Care for the Elderly. It provides important meal, health and homemaker services to over 25,000 frail elderly. In my travels around the state, people tell me over and over that their primary request is to stay in their homes. The Community Care for the Elderly Program is specifically designed to help them remain in their homes, with family and friends, for as long as possible. This program is so important to so many elderly people but because its current budget is inadequate it does not reach as many as need its services. As an advocate who is deeply committed to community care for the elderly, I appreciate the support of the Florida Medical Association Auxiliary. I urge you to continue so that we can expand our services and help more older people who are truly in need.

Many older adults are partially or totally dependent on the state and I am proud that we have programs such as Community Care for the Elderly to take care of them; however, looking at just this segment gives a very distorted view. While many older citizens depend upon the state for their well-being, the majority are in good health, have adequate incomes and live independent, self-sufficient lives. These people are one of our greatest resources. They contribute their time and love and experience to hundreds of programs in communities all over the state.

In rural north Florida a retired football coach from Florida A&M University conducts physical fitness classes for his contemporaries. In another north Florida town, an elderly woman volunteers her time to operate a public library. Down in central

Florida, a group of retired executives and businessmen provide free consultation and technical assistance to members of their community. In Sarasota, retired physicians and medical personnel provide preventive health care, health screening and counseling to indigent people. In several cities, retired musicians have joined together to entertain nursing home residents and retired craftsmen repair the homes of elderly citizens.

Over 7,900 senior citizens are volunteering in our public schools. A program called Senior Mentors matches an older person who has demonstrated outstanding achievement with a child who has potential for achievement in that same area. Together the old and the young explore such topics as medicine, astronomy, art, dance, writing, nature study, music and mathematics. This wonderful program was started by the Broward County Medical Association Auxiliary.

Several other programs the Florida Medical Association and its Auxiliary are involved in have also touched the lives of older Floridians. The Medi-File card has made it easy for seniors to keep up with their medications and for physicians to know what drugs other doctors are prescribing. Your "Health Notes for Older Adults" has been extremely useful in providing updated health and nutrition information geared specifically to older adults.

I am proud of your advocacy for older people. Your work is part of Florida's history-making journey that will lead our state — and the rest of the nation — to a more enlightened treatment and appreciation of its older citizens.

Mrs. Adele Graham
First Lady of Florida

Community care for the elderly

Barbara M. Palmer, M.A.

ABSTRACT: The Community Care for the Elderly program is a service program authorized by Florida Statute 410.021-410.029 and administered by the Department of Health and Rehabilitative Services through contracts with area agencies on aging. Area agencies on aging contract with lead agencies to provide services to eligible functionally impaired elderly persons, 60 years of age or older, living in their service area. All of Florida's 67 counties have a lead agency responsible for the Community Care for the Elderly Core Service program. The budget for this fiscal year includes $21.8 million in State Funds matched by at least ten percent in local resources. Almost 24,000 frail elderly received two or more services from this program last fiscal year for an average cost of $868 per client.

The Author
BARBARA M. PALMER, M.A.
Mrs. Palmer is a Senior Human Services Program Specialist for the Department of Health and Rehabilitative Services, Program Office of Aging and Adult Services, Tallahassee.

The Community Care for the Elderly program is a service program for functionally impaired elderly persons, 60 years of age and older, administered by contract between the Department of Health and Rehabilitative Services and eleven area agencies on aging.

An area agency is the agency designated by the department to develop and administer an area plan for a comprehensive and coordinated system of services for older persons in each of the department's eleven service areas. These eleven area agencies on aging also plan and fund the community care service system for their area. As an example of a service area, District 4 serves a seven county area comprised of Baker, Clay, Duval, Flagler, Nassau and Volusia counties.

Each area agency on aging contracts with local agencies, public or private, such as Councils on Aging or county governments to coordinate services for functionally impaired elderly persons, to provide case management, to provide three or more core services, to compile community care statistics and to monitor sub-contracted services.

To use District 4 again as example, the Northeast Florida Area Agency on Aging contracts with the Baker County Council on Aging to administer the Community Care for the Elderly Program while in Duval County, it contracts with the Visiting Nurses Association.

The annual contract between the area agency and its lead agencies sets the cap for expenditures, thus Community Care for the Elderly is not an entitlement program.

Program Objectives • When the Community Care for the Elderly Act was passed by the Florida Legislature and signed into law by Governor Bob Graham

in 1980, the objectives of this landmark legislation were threefold and have not been amended. These three objectives are:

1. To assist functionally impaired elderly persons in living dignified and reasonably independent lives in their own homes or in the homes of relatives or "caregivers" through the development, expansion, reorganization, and coordination of various community-based services
2. To establish a continuum of care so that functionally impaired elderly persons age 60 and older may be assured the least restrictive environment suitable to their needs.
3. To develop innovative approaches to program management, staff training, and service delivery that have an impact on cost-avoidance, cost-effectiveness, and program efficiency.

The first appropriation was for a six month period, January 1 to June 30, 1980. Accompanying the appropriation were instructions for the Department to implement at least one community care service system in each of the eleven districts. With this funding 44 counties were served and approximately 6000 functionally impaired elderly were served. The CCE Act also defined that a functionally impaired elderly person was any person, 60 years of age or older, with physical or mental limitations which restrict his or her ability to perform the normal activities of daily living and also impede his or her ability to live independently without the provision of core services. Subsequent appropriations designated the use of the funding to continue expanding the core service program to assure that all counties had lead agencies and to increase the number of individuals served. The current appropriation designates the use of the increase to prevent admission to nursing homes for those who are otherwise eligible for nursing home care through Medicaid's pre-admission screening procedures. The priority for service has and continues to be for those at risk of institutionalization. The underlying assumption is to develop a continuum of community based services so that there is an alternative to institutional care and that institutional care will be utilized when appropriate rather than as "there was no other alternative."

Program description • The Community Care for the Elderly Program is being developed to become a service network comprised of a variety of home delivered services referred to as "core services" for functionally impaired elderly persons. This service network provides services by a variety of agencies but services are coordinated for the eligible individual by the lead agency as well as providing three or more core services. While all lead agencies must provide case management, the choice of core services offered is dependent upon the characteristics of the service network of the county or area served. Funding for core services has also limited the number of core services funded. For purposes of the Community Care for the Elderly Program, core services were listed in the authorizing legislation as homemaker, chore, respite care, adult day care, medical transportation, mini-day care, home delivered meals and health maintenance services. Services which are included in the health maintenance services are medical therapeutic services, personal care, home health aide, home nursing services and emergency response systems. Until 1984, when the appropriations restrictions were omitted, medical therapeutic and home nursing services could not be funded with CCE funds. To illustrate the core service coverage in Florida, all lead agencies offer homemaker service in addition to case management, 55 offer personal care, 46 offer respite, 45 offer medical transportation, 33 offer home delivered meals, 36 offer chore, 26 offer emergency alert/response service, 19 offer adult day care and the remaining services are offered only by a few lead agencies. As can be seen by this listing, the services most frequently provided are social services which need trained providers under professional supervision. The statute instructs lead agencies to utilize other funding resources prior to using CCE funds. There is broader health insurance coverage for medical therapeutic and home nursing care thus the need for these services has been less. Current comments from the lead agencies indicate that the hospital discharge referrals to their projects are increasing but their client quota is at capacity. Thus, the expectations may, in many areas of Florida, be greater than resources available for this program for acute short-term care.

When someone calls a lead agency to request services, an initial interview is completed to screen, as best they can, whether the individual needs the core service program. If, in the judgment of the interviewer they do, a home visit is scheduled to conduct a formal assessment of the individual situation and thus determine eligibility in the areas of age, functional ability and risk of institutionalization using an assessment form required by the Department. If eligible, and resources are available, a case plan is developed with the individual and family, if any, or friends or neighbors who may be providing some support. While income is not an eligibility requirement, if the individual has resources above expenses, some or all of the cost of services is assessed for payment. The amount, frequency and duration of the service (or services) is arranged, referrals to other agencies are made, and monitoring of the service initiation is conducted. Approximately 45 percent of CCE clients live alone with little or no participation in outside activities or contact with relatives or friends. Rural and urban clients differ

only in that urban clients are more apt to live alone and have fewer contacts with friends or relatives. Nearly two-thirds of those receiving one or more core services are 75 years of age or older, 22 percent are 85 years of age or older. Approximately one-third of the clients leave the program on an annual basis. The primary reasons for attrition are due to death, improvement in functioning or nursing home placement for these individuals. But the majority of clients are long term or remain in the program a year or more.

Developmental issues • The Community Care for the Elderly Program is now in its fifth year of operation. Resources have been focused to implement the program in each district and then in each county to meet a greater number of functionally impaired elderly persons need for community based or in-home services in a cost-effective manner. It is anticipated that the next development will be to work towards achieving a more complete continuum of care available throughout Florida as resources become available for Florida's functionally impaired elderly citizens.

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Population aging as progress, not as burden

Harold L. Sheppard, Ph.D.

ABSTRACT: The aging of the American population—partially as a result of great progress in extending life expectancy—should not be lopsidedly seen as a catastrophic burden on the younger population, who themselves will live to be old. Moreover, we are undergoing an upward redefinition of when *old is old: the age at which individuals today believe a person starts to become "old" is higher than in the past. Much of this shift is related to improved health and lifestyles of Americans, which persists into "old age."*

Negative reactions to population aging nevertheless persist. The aged are either envied as too well off or resented as a burden to the economy. Instead, we should be mature enough to accept the consequences of a cultural emphasis on good health services, excellent medical technology, and positive nutrition regimens, i.e., a growing older population. Longer lives should not be viewed as a threat to private and public budgets. A balanced perspective recognizes the principle of interdependence between generations, and the contributions made by the elderly today (and in the past, when young) to the society and economy.

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My friends and associates might level charges of "Pollyanna" at me, but I have a hunch that our country—despite (or along with) its schizophrenia about the elderly and becoming "old"—is subtly going through a positive shift in viewpoints and attitudes about the "facts of later life." In a nutshell, the underlying transformation has to do with when it is that Americans believe men and women start to become "old." Scientific gerontologists correctly insist that we should not use chronological age in making decisions and judgments about individuals but they are fighting a difficult uphill battle. Americans, as well as human beings elsewhere, will continue to use "old" to mean negative, deteriorating, deleterious biological and psychological conditions in human beings. I do not think we will ever see the word vanish from our vocabulary.

When is old? • But the real issue is, when is old? Myrna Lewis and Robert Butler, nationally and internationally known gerontologists, point to a greater awareness in our mass culture of a continuity of active, "youthful" behaviors and attitudes among age groups previously viewed as "to old" to be behaving and thinking the way they now do, e.g., continuity of sexuality, sustaining or renewing close, interpersonal relationships, career changes, and artistic creativity. Books written 20 years ago with such titles as "Sex after 60" now have to be retitled "Sex after 70" (or even later). The allowable mandatory retirement age has been raised from 65 to 70.

The main point is that Americans, in interviews asking when does the average man or woman become old, have been giving chronological answers with a higher average figure than in previous years. For example, in 1974, adults under 65 gave, on average, the age of nearly 63 in a survey for the National Council on Aging by Louis Harris. The remarkable

thing is that seven years later the median age offered was three years higher—66. A jump of three years is indeed an impressive trend over a period of only seven years.

The encouraging news, in addition to this overall shift, is that regardless of a person's age the higher his or her education the greater the age at which that individual believes people start to become "old." For example, for those 18 to 54, the college-educated say (on average) 67 contrasted to only 63 among those with less than a high school degree. It is not surprising that retired persons give a lower age than those of the same age still in the work force. This is, understandably, related to health status. The median age given by people 55-64 years old who state their health is excellent or pretty good was, in 1981, nearly 69, more than four years over the figure given by people of the same age but with only fair or poor health.

This last finding is one more reminder of the value of good health as an indispensable ingredient for a positive self-image. It also reinforces my earlier proposition that "old" has negative connotations. While it is still a controversy among specialists or experts in aging, some of us believe that the typical health status of a given age group of today's senior citizens is superior to that of senior citizens of the same age group ten or 20 years ago. For what it is worth, and I think it is worth a lot, the vast majority of today's older Americans (65, 70, or 80 and older) themselves believe that's a fact (Table 1). They are in a good position to know, being able to think back about their older relatives and parents of years ago. Even among those under 65, nearly two thirds feel the same way.

If we combine the fact that better-educated Americans think "old" begins later than other Americans do with the further fact that healthy people, compared with less healthy ones, also think the same way, and then add to the resulting combination that education and health are both improving, we have some solid grounds for optimism about the future of living longer in America. As for us in Florida, given its high proportion of residents 65 and older (about 18% compared to only 12% for the nation as a whole), the scenario is much more promising than a lot of journalistic accounts would have us believe.

The "news worth reporting" understandably tends to focus on adversity and problems, one might even say the unusual or the bizarre. To use an analogy, newspapers, TV and radio programs cannot possibly report every safe landing of an airplane. They only report crashes and other airline mishaps. Obviously, we should not use such sources for a comprehensive perspective concerning travel by plane. None of this is meant as an argument against reporting trends in poverty among the elderly, or which groups among the elderly have the highest rate of poverty, for example. There is always some unfinished business, or new developments, that need to be tackled. But in working on unfinished business, in tackling new developments, we must not lose sight of the progress made so far in raising the well-being of older Americans and in pushing higher the age point at which we start to become "old."

Increased life expectancy • This type of progress is something all of us should be proud of but there are still too many complaints that our senior citizens are too well-off; that is is not fair; too many voices provoking intergenerational tensions. If we as a nation insist (rightfully) on having and using the best of health services and medical technology in the world, and stress the value of good nutrition, exercise and nonsmoking, why is it that so many citizens nevertheless cannot recognize that one of the consequences of superior health services and technology, and improved lifestyles, is an increase in life expectancy? If an increased life expectancy is so much to be valued and sought after, we have to be big enough, imaginative and resourceful enough, to accept the consequences. In this case, the consequences include a larger than previously expected population of persons in their 60's and older. This progress, to be sure, raises new questions and unanticipated dimensions for which we need to be prepared. But longer lives should not primarily be seen as a threat to private and public budgets.

For example, nearly 15 years ago, we were told by the population and gerontology experts that by 1990 we would have about 27½ million people 65 and older. Now the figure for that year (only five years away) is over 32 million! There will be at least 4½ million more "older" Americans than predicted in 1971. Why such discrepancy? The basic explanation is that, contrary to the assumptions of only the recent past, mortality rates among middle-aged and older adults have been plummeting. This is true especially in the case of deaths due to heart diseases. There are now more men and women, say 45-59 years old, 60-64, and so on, and they in turn will live into even higher age brackets. This is a notable achievement.

Table 1. — "Do you agree or disagree that older people today are healthier than older people were 10 or 20 years ago?"

	18-64	65-69	70-79	80+
% Agree	63	71	70	75

Source: 1981 National Council on Aging Survey by Louis Harris and Associates.

While I could couch the implications in Cassandra-like terms, I prefer to talk about challenges of inescapable realities. One of these implications for which we, especially in Florida, must be readying ourselves in our private, professional, and public roles, and institutionally, relates to the rapid trend toward an increasing proportion of men and women about to retire, or recently retired, say, 60-69 years old, who will have older parents and relatives still alive. The other way of expressing this is that a decreasing proportion of persons, say, 85 and older (mostly women), will have adult children and other younger relatives to count on for material and social-psychological support.

The figures in Table 2 reveal the remarkable trends in these proportions for the United States, according to official government sources. They tell us that in 1970, slightly more than 10% of the population, sometimes called the "young-old," had older parents and relatives still alive. (I am using the total census statistics as proxies for the actual data on how many 60-69 year-olds have living parents and older relatives.) Fifteen years laer, in this year 1985, the proportion increased by roughly 40%, to 14.7%. By the year 2000, in another 15 years, we can expect the proportion to be roughly 2½ times the porportion of 1970. In other words, more than one out of every four Americans will have parents and older relatives still alive in 2000 A.D. The ratio today is about one out of seven. Fifteen years ago (in 1970), it was only one out of every ten.

The obverse of these data is that 15 years ago, the "very old"—85 and older—had many more children, nephews and nieces as potential and actual support sources, whether in the same household or not, than the "very old" of today, and especially those around the turn of the next century. In 1970, there were nearly ten "young-old" for every one "very-old" American; nearly seven today (1985); and in sharp contrast to those two ratios, by 2000 A.D., for every "very-old" American there will probably be less than four "young-old."

Given the unique nature of Florida's elderly population, consisting of a large number who moved here without other, younger family members, the ratio is much lower than the overall national one

Challenges and issues • These demographic statistics form the context within which challenges and issues must be understood and dealt with. There is no need to repeat here the data on the greater risks in terms of health and social service needs for the 85-plus population and the corresponding costs involved. The issue is, to what extent can we count on the "family" to provide the care and/or the costs of such care in the years to come? "Costs" include more than dollars and cents: time, genuine emotional support, and actual direct provision of care can also be treated as costs.

With the best of intentions on the part of the "very old" population's "children" and other younger relatives—themselves already in their 60's—there just will not be very many of them available (at short or long distance) to provide or to pay for such care. In Florida, far fewer "very old" have "young-old" children, nephews, and cousins living here to serve as providers of various services. Substitute families are critical, and one of these frequently consists, on the informal level, of persons of the same ages, although it is not yet clear whether such "surrogates" are or can be as satisfactory as the "real thing." Volunteer activities also become even more valuable in the Florida environment.

The burden issue • This particular set of statistical trends may evoke more anxieties than are necessary, depending on one's point of view. Although the overall economic and health situation of the elderly may be improving, we have some way to go toward correcting some damaging and conflicting perspectives concerning the role and "reputation" of the elderly in society as a whole. One of these perspectives is too heavily biased in the direction of viewing population aging as a "burden" to the rest of society, or to the economy. In contrast to this perspective is

Table 2. — "Family Age Dependency" Ratios, 1970 to 2000.

	1970	1980	1985	1990	2000
A. Population 85 and Older / Population 60-69	10.4	13.6	14 7	16 9	26.5
B. Population 60-69 / Population 85 and Older	9.6	7.3	6.8	5.9	3.8

Based on data from sources:
For 1970, U.S. Bureau of Census, Current Population Reports, p. 25, NO. 470, "Projections of Population of the United States by Age and Sex: 1970 to 2020," 1971.

For 1980-2000, Social Security Administration, Office of Actuary, Social Security Area Population Projections, 1981, Study No. 85, July, 1981.

another damaging one that exaggerates how well off the aged are in America, indeed how unfair it is that they have it so good. Both perspectives share in common a resentment and/or fear of population aging. Both, when translated into policy terms, would pit the nonaged against the aged. Both perspectives are fed and reinforced by a philosophy of narcissism (obsessive self-centeredness) and rejection of intergenerational obligations.

Ignorance, too, plays a role. Preoccupation with the "burden" image of the elderly ignores the variety of the contributions they provide in such areas as job creation. I refer here not only to employment opportunities in the "aging industry", e.g., physician services, nursing homes, pharmaceuticals, etc., but to other positive economic effects of an aging population. The Federal Reserve Bank of Atlanta in its June, 1984, issue of "Economic Review", as a case in point, reported an economic study which shows that "many counties in the southeast could become less vulnerable to recessions if the steady influx of a new breed of more prosperous senior citizens continues. . ." A larger proportion of the income of older families is discretionary, and thus spending tends to be relatively unaffected by the state of the local or national economy. They often have less income than younger families but "they have proportionately more to spend." A higher percentage of their income is spent on food, medical care, utilities, travel, and eating out.

A Pinellas County Planning Department report on "The Economic Impact of the Elderly on Pinellas County" in mid-1984 points to the excess of benefits over costs as one of the positive effects of an older population in the community. Private sector jobs for nonaged are created by the expenditure patterns of the elderly in food stores, restaurants, finance, insurance, and real estate. These jobs are over and above the obvious ones associated with the delivery and provision of social and health services in the public and private sectors. Finally, Florida's elderly help broaden the tax base, especially because of the high rate of home ownership.

A truly comprehensive and balanced approach to the "burden" issue would thus recognize the interdependence among different age groups, to the importance of the old to the young, and vice versa. A more jaundiced pro-elderly advocate might be tempted to paint the young of many ages as "parasites" living off the current income and other contributions (including volunteer services) of the retired, and benefiting from the heritage of previous productive contributions of today's elderly when they themselves were young. Before young and middle-aged adults are provoked into developing "ageist" antagonisms, they should remind themselves that they might be engendering even more long-lasting public resentment of their own "future selves."

I believe this orientation is one that will become increasingly imperative as Florida begins to face the challenge of developing a more mature philosophy and public policy regarding the provisions of those services necessary to care for the burgeoning population of the very old among the state's senior citizens.

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The aging skin

Sheldon V. Pollack, M.D.

ABSTRACT: Wrinkles, skin discoloration, cutaneous laxity, the appearance of a variety of benign and malignant skin lesins, and graying of the hair are all telltale signs of increasing age. These age-related cutaneous changes are accompanied by an increased susceptibility to skin diseases in the elderly. A number of attendant morphological skin changes have been documented in aging, but only minimal fundamental understanding of this process exists. In recent years, investigation into the mechanisms of aging has intensified, resulting in an increased body of knowledge relating to the intrinsic, and extrinsic aspects of skin senescence. Much research remains to be done before we can consider having a significant impact on the modulation of aging in the skin. In the meantime, patients should be educated with regard to the prevention of actinic skin damage.

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Changes in the skin and its appendages, including cutaneous thinning, laxity, wrinkling, lentigines, vascular changes, and graying hair are all outward signs of advancing age. These cutaneous alterations result from a combination of inherited predisposition, intrinsic physiologic effects and external forces to which the skin is exposed during the course of a lifetime. In addition to the cosmetic and emotional effects of cutaneous aging, senescent skin is accompanied by an increased prevalence of skin disease. A recent United States Public Health Service survey showed that 65% of persons 65 years of age and older were so afflicted.[1] Aging skin, therefore, has medical significance, particularly in light of the rapid increase, during this century, in the proportion of Americans over 65 years of age (currently approximately 12%).

Tindall and Smith[2], in a study of 163 persons 64 years of age or older, found cutaneous laxity in 94%, asteatosis in 77%, and hyperproliferative lesions such as actinic or seborrheic keratoses, angiomas, or lentigines in 50-90%. In addition, skin cancers, a variety of dermatoses, certain bullous disorders, and some viral infections of skin were frequently encountered.

Until recently, little attention has been devoted to the subject of gerontologic dermatology. Useful morphologic and functional data are presently available and such knowledge will hopefully be expanded in the future. At such time, it is possible that, because of its accessability, the skin will come to serve as a general model with which to study aging phenomena. In the present communication, various aspects of our knowledge of cutaneous aging will be reviewed.

Histologic and functional changes in aging skin • Despite a general lack of knowledge regarding cutaneous aging, certain morphologic and functional skin changes have been recognized to accompany senescence. The individual structural components of the skin have been studied in order to better understand frequently encountered cutaneous findings in the elderly.

The epidermis, which, in youth, is firmly anchored to the dermis by means of regular downward interdigitations, becomes irregularly flattened with age. As a result, dermal-epidermal separation occurs more readily in older skin, accounting for the frequency of abrasions after minor trauma and blister formation in edematous sites. There appears to be a diminution in skin markings with age[3], probably related to the flattening of the epidermis described above. The individual epidermal cells become disorderly, both in shape and organization. Their staining qualities change and glycogen appears in the upper layers of the epidermis. There is an age-associated decrease in epidermal renewal rate, resulting in significant prolongation of healing in experimental epidermal wounds[4]. The outer horny layer of the skin (stratum corneum) is the principal barrier to movement of molecules through the skin in either direction. Although the thickness of the stratum corneum does not change in the aged, the individual corneocytes are larger. Barrier function may decrease, particularly with regard to the transepidermal absorption of materials applied to the skin surface. However, transepidermal water loss does not appear to increase with age[5].

Epidermal appendages also undergo senescent changes. There is a diffuse reduction in the number of hair follicles in the scalp, accompanied by diminished nail growth. Sebaceous gland function, as manifested by surface lipid levels, decreases in the elderly in association with the concomitant decrease in endogenous androgen production. In males, sebum levels remain essentially unchanged until the age of 80 years. In women, there is a gradual decrease in sebaceous secretion from menopause through the seventh decade, after which no appreciable change occurs[6]. Despite their diminished activity with age, sebaceous glands exhibit a tendency to enlarge in the elderly[7], presumably due to decreased cellular turnover. Morphologically, individual sebaceous cells fail to show any abnormalities[7]. However, increased numbers of undifferentiated cells can often be seen to arise, in clusters, from the follicular epithelium of sebaceous follicles[8]. The hyperplastic, relatively inactive sebaceous glands of the elderly of either sex remain responsive to androgenic stimulation throughout life, as evidenced by increased sebum output following testosterone[9] or fluoxymesterone administration[6].

With aging, the number of active eccrine sweat glands is reduced and sweat output per gland is diminished both in rate and amount. The sodium content of sweat is also substantially reduced. Morphologically, the secretory cells flatten and become atrophic. A progressive accumulation of lipofuscin is found in the cytoplasm of the glandular epithelium.[10]. The adrenergic response is reduced in both sexes, while the cholinergic response decreases in males and increases moderately in elderly females.

The majority of apocrine glands in the elderly remain essentially unchanged with regard to structure and function, although there is a tendency towards attenuation of the secretory epithelium and dilatation of tubules. Since they are hormonally influenced, there is some reduction in activity of these glands.

Changes in the pigment-producing melanocytic system of the skin are also found in aging. The number of DOPA-positive melanocytes (those actively producing melanin) progressively decreases both in exposed and covered areas and pigmentation is seen only in epidermal cells in contact with such melanocytes. The increase in senile lentigos on the exposed skin of elderly persons is due to localized proliferations of melanocytes at the dermal-epidermal junction, presumably as a result of chronic ultraviolet light exposure. Graying of the hair is accompanied by a reduction in the number of melanocytes in the hair bulbs and a decrease in melanin formation by those that remain. White hair bulbs are lacking both in pigment and melanocytes[11].

Senescent dermal changes involve collagen, elastic tissue, nerves and blood vessels. These age-related alterations account for many of the most obvious gross external manifestations of aging. As age increases, less collagen is produced by dermal fibroblasts, resulting in significant thinning of the dermis. The turnover of older collagen decreases and this becomes thickened and relatively insoluble due to increased cross-linking. Collagen becomes stiffer and less elastic with age and there is a decrease in the ratio of mucopolysaccharide to collagen[12].

Elastin, an extensible protein which makes up approximately 2% of the dry weight of the dermis appears, like collagen, to undergo changes with age. These changes are morphologically difficult to distinguish from those induced by actinic damage, although the latter are generally more severe. In both situations one can observe a progressive thickening of dermal elastic fiber arcades into curled and amorphous masses. Pearse and Grimmer[13] found a nearly threefold relative increase in dermal elastin between ages 20 and 80 years.

Aging is accompanied by minimal changes in cutaneous neural structures. Montagna[14] has observed that the number of Meissner corpuscles seems to remain unchanged. There is, however, en-

largement and distortion of these specialized nerve endings. The genital corpuscles in the genital mucous membranes do become smaller and many disappear. In addition, much of the superficial nerve net underneath the epithelium in the vagina disappears in old women.

Superficial cutaneous blood vessels generally undergo some degeneration with aging, particularly in the bald scalp. There is collapse, disorganization, and even total disappearance of the superficial microvasculature in both exposed and non-exposed portions of the skin. The deep dermal vessels also diminish in number and those that remain demonstrate thickened vascular walls. Undoubtedly, the elderly suffer, in general, from diminished cutaneous circulation. The consequences of this diminished blood supply may be considerable[5]. Many of the cutaneous problems of the elderly are traceable to vascular insufficiency. Baer and Schwarzchild[15] observed many years ago that dermatoses of exogenous origin tend to persist longer in the elderly and are more difficult to treat. In these situations, there are probably a number of vasculature-related factors at work. One of these is the fact that acute inflammatory reactions are subdued in aged skin, as was demonstrated by Bettley and Donoghue[16] who found fewer irritant reactions in persons past 50 years of age tested to toilet soaps. This lack of response to an inflammation-producing stimulus can result in continued exposure to potentially harmful agents which may cause cutaneous damage. In addition, because of diminished blood flow, external contactants and irritants are not speedily removed from the skin surface, resulting in ongoing symptomatology. The cutaneous vasculature normally plays an important role in thermoregulation. Reduced circulation in the elderly predisposes them to the development of hypothermia with even brief exposure to cold[17]. It would follow that hyperthermia in the elderly, which often occurs in severe heat spells, is also related to thermoregulatory difficulties arising from a compromised cutaneous vasculature. Senile purpura, common in aged skin, is generally held to be a result of diminution of the vascular support tissue, collagen and ground substance, rather than due to alteration in the vessels themselves.

Immunologic changes in aging • With increasing age, alterations in immune function become apparent. These changes have cutaneous implications in that many of them are associated with defense against or response to such age-associated skin diseases as bacterial and viral infections, autoimmune diseases and cancer[18].

Involution of the thymus occurs throughout adulthood, leading to altered immunological responsiveness[19]. There is a rise in the prevalence of autoantibodies[20] which may contribute, for example, to the increased incidence of pemphigus vulgaris and bullous pemphigoid in the elderly. Benign monoclonal serum immunoglobulins also appear in up to 3% of elderly patients[21]. This is accompanied by a decline in "useful" antibody titres to heterologous antigens and isoantigens[22]. Interferon production is diminished. T-cell functions also decline in elderly patients, resulting in decreased cell mediated immunity. In vitro studies of T lymphocytes have demonstrated a slight decrease in their number[23], as well as a significant decrease in responsiveness to standard mitogens during the later decades of life[24]. These alterations in T-cell functional capacity appear to be the most profound age-related change in the immune system. The observation that old people with defective cell-mediated immunity have a decreased life expectancy suggests that this particular deficiency may be important in pathogenesis in the aged[25]. Recently, in the skin of experimental animals, investigators have demonstrated that exposure to ultraviolet light alters the immune system, facilitating the devlopment of fatal skin tumors[26,27]. This is a specific immunologic tolerance of UV-induced tumors and appears to be related to the development of suppressor T-cells that prevent tumor rejection[28].

Causes of cutaneous aging • A single unifying concept to explain the mechanism of aging has not yet been developed. A number of theories which attempt to explain aging exist, but none provides an entirely satisfactory explanation for all observations in aging. Most observers of the aging process recognize a multifactorial contribution to aging of the skin. Heredity, physiologic influences, and external insults all combine to affect the overall senescent patterns observed. Skin appears to "age" at different rates in persons of different genetic constitution. For example, black-skinned individuals often do not exhibit the degree of skin aging seen in white-skinned persons of the same age. Even within a particular racial group, skin aging is inconsistent. These findings, however, are not necessarily indicative of differences in intrinsic aging but, rather, suggest a genetic predisposition to sustaining increased (or decreased) damage from external sources, the most important of which is ultraviolet radiation. Investigations by Lavker[29] demonstrate that the senescent changes found in non-exposed and exposed skin are qualitatively the same, but the latter are more pronounced.

The most dramatic instance of genetic susceptibility to actinic damage is found in xeroderma pigmentosum, a condition in which severe premature skin aging, including the development of multiple cutaneous malignancies, occurs. The basic genetic defect is a deficiency of enzymes necessary to repair the DNA damage caused in the skin by incident

ultraviolet light. One might speculate, then, that aging in the skin may be related to alteration or diminution of certain skin enzymes in the elderly. Work by Yamasawa et al[30] failed to reveal any specific epidermal enzymatic alteration related to aging. Lambert et al[31], however, did show a decrease in the capacity for repair of ultraviolet induced DNA damage in subjects with actinic keratoses. Moreover, an age-related decline in ability to repair DNA following in vitro irradiation of skin fibroblasts obtained from both exposed and non-exposed areas was demonstrated by Sbano and co-workers[32]. Of note is the fact that at least one study has shown a correlation between obtainable life span in a variety of mammals and the extent of repair for at least one type of DNA lesion[33], suggesting that DNA repair capacity may be a determinant of aging.

Management of cutaneous aging ● It is evident from the foregoing that our current knowledge of skin aging is fragmented and incomplete. Certain morphologic features are recognized to take place in aging skin but the mechanisms involved in causing these changes remain to be elucidated. Future investigative efforts will hopefully endeavour to provide further insights into the nature of intrinsic aging and factors that modulate this process. In the meantime, we can attempt to minimize the degree of extrinsic skin "aging" in our patients by educating them with regard to the folly of reckless actinic exposure. They should be encouraged in the daily use of effective sunscreens and protective clothing. Outdoor activities requiring a prolonged exposure to ultraviolet irradiation should be scheduled so as to avoid the intense midday sun.

Corrective cosmetic procedures including surgical rhitidectomy, dermabrasion, chemical peel, topical chemotherapy and collagen implantation are supportive, but temporary measures in the battle against loose, discolored actinically-damaged skin. These cannot and should not be expected to undo the ravages of time occurring in the skin and are secondary in value to preventative intervention, which should commence at an early age.

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Program of health education for people 55 and better

Clayton V. Hansen

ABSTRACT: Many senior citizens tend to ignore good health habits. Indifference to a healthy lifestyle usually results in premature illnesses, expensive medical care, and early death. Many seniors will not take the time to practice techniques that would result in better health. The strategies presented here should help improve a person's lifestyle.

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Our nation is on a high, encouraging people to become physically fit. Physical fitness, of course, is for everyone; at certain ages there is no choice — it becomes almost obligatory. The one stage in life, however, in which a person is most likely to have freedom of choice is within the retirement years — ages 55 or better (55 and "older" seems to have a tone of finality, "better" tends to sound optimistic). The question is, will the choice be to develop a healthy lifestyle by combining proper exercise, diet, relaxation, self-care guidelines and acceptance of self? Secondly, how do you motivate people to take the time to become physically fit? The answers to these questions, based on the frailties of human nature is "probably not," and "it won't be easy." In fact, in our culture, people will take time to do almost anything else. Health requires taking time — 20 to 30 minutes a day, three days a week. Excuses abound: I'm too old, I served my time, I hate to sweat, I'm too busy, I don't know how, and besides, who cares? All represent an attitutde suggestive of a lack of knowledge, lack of desire, and surrender. According to the AMA, 55% of all diseases, are lifestyle-related. People are living longer, thanks to all health care professionals, but living longer results in a unique set of problems.

People 55 or better are going to experience diseases, some not even identified yet, related to the "aging process." To quote Dr. John W. Rowe, of Harvard Medical School, the average 85-year-old has a longer life expectancy but that life expectancy is dominated by disability. Dr. Rowe's statement is very conclusive but you do not have to accept it as a fact without first looking at alternatives that might be helpful in making the disabilities less dominant. With the foregoing thoughts in mind, what can and

should be done to make the aging process more comfortable, enjoyable, productive and relaxed? Certainly not crying, "Poor me!"

The program • Recognizing the need, the Easter Seal Society of DeSoto, Manatee and Sarasota Counties decided to sponsor a health education program for senior citizens. The format consisted of one introductory meeting and four workshops. It was also determined that the workshops should be held in neighborhoods, condiminiums, churches, mobile home parks, wherever people meet, rather than at the Easter Seal Center. The outreach concept is intended to generate peer pressure which helps further the program after the Presenters complete the workshops.

The introduction is an overview and if the people like it the workshops are scheduled weekly for four weeks. The participants are expected to be actively involved. The first workshop discusses vital signs — pulse rate, blood pressure, temperature, breathing and how the body responds, particularly when exercising. The group performs exercises under the direction of the Presenter. The negative results of inactivity are outlined and emphasis is upon overcoming anxiety, depression and systematic routines for helping individuals feel good about themselves.

The second class begins with a stretching activity and is followed by more exercise, massage and relaxation training. This is fun, an affair with everyone lined up columnwise and massaging their neighbor's neck and shoulder muscles. People laugh and joke with each other and humor, so important to well-being, is encouraged. People are urged to take time for their health. Daily habits are examined to find ways to change, so beneficial healthy practices can be started.

Proper breathing techniques are detailed in the third session. Correct methods are demonstrated and the group takes an active part. The importance of good posture as an aid to breathing is demonstrated with group participation. More exercise and massage follow. Relaxation skills are demonstrated with discussions about aging, stress, anxiety, attitude, anger, depression, overweight and self-care guidelines.

Workshop four emphasizes self-care guidelines: fun, massage, skin care, diet and nutrition. Throughout the entire program, the participants are enouraged to take time for health, to laugh and become partners with their physicians by keeping their own records in writing: family history, health professionals they have contacted, kinds of medication — how, when and why they are used — illnesses or accidents, dental records, blood pressure and pulse. Care of the feet is seriously discussed, as well as the use of sun block and meaning of the rating numbers.

Observations • Over 2,500 people have participated in the program. More women attend than men — 85% to 15%. Women are definitely more aware of the importance of being healthy and much more willing to take the time to do whatever is necessary to maintain good health. Each participant was asked to fill out an evaluation form after completion of the workshops. All found the program enlightening and of value. The workshops were rated in each instance "very good" or "it was great." People in mobile home parks seem to have close relationships with each other. They are very active — bridge, golf, exercise classes, going to school, volunteering and going on sight-seeing excursions. Residents of condominiums, generally of a higher economic status, are involved in many of the same pursuits but were not as closely knit. Neighborhood groups, i.e., individual houses, usually did not have a close neighborhood relationship and the participants as a group tend more to club associations or church. Overall the workshop participants were enjoying life, seeking intellectual or physical self-improvement goals and appeared to be satisfactorily affluent. No obvious loneliness was observed. Most were optimistic about the future, but did have concerns about insurance, Medicare, supplemental insurance, high cost of medical care, indifference of physicians, and refusal of physicians to take assignments.

Finally • There is nothing new under the sun. Good health concepts and prevention of disease have been around for a long time. A book published in 1912 by Sanford Bennett, "Old Age, Its Causes and Prevention," is nothing more than the precepts in this article.

As senior citizens of today, have we, in fact, developed lifestyles that combine the concepts that prepare us for a healthy life? A few have, many have not. Have we taken the time to act upon the proven rules of healthy lifestyles? Again, the answer is a few have, many have not. We complain about the high cost of medical care and insurance premiums but do not question the medical care bill, the treatment, or the medication. The medical profession is not at fault — certainly there are many incidences of success. We are living longer and there is practically no polio, communicable diseases or tuberculosis (to name a few). We have not become involved in good health practices and prevention of disease.

Prevention is the only way we can change the current system. We must begin to maintain good health practices; the choice is ours. There is no royal road to health. You must follow the precepts of good health practices — exercise at least 20 minutes a day, three times a week, eat breakfast, three balanced meals a day, moderate use of alcohol, no smoking, drink six to eight glasses of water a day, maintain a

moderate weight, get seven to eight hours sleep each night, think positive and have a good sense of humor. After all, the trials and tribulations of childhood, youth, young adult and midlife, for most of us, are not our problems. Enjoy.

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Lifelong learning: prescription for health

Virginia Lukens Elgin, M.A.

ABSTRACT: There are many educational opportunities and facilities for the older person in Florida, especially the St. Petersburg-Tampa Bay area which has one of the highest concentrations of people over age 60. The experiences of several older persons give a consumer's view of attending school late in life. Evidence is presented which supports the importance of education for enhancement of the older person's physical and mental health.

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Old dogs can learn new tricks, especially if they are healthy and motivated; furthermore, they often perform better than young ones. Alan B. Knox (1977) in "Adult Development and Learning" reports that the most positive conclusions are from longitudinal studies. Intelligence, problem solving, recall of meaningful information, and recognition memory do not deteriorate; critical thinking actually improves. It has also been found that the older, more experienced individual tends to be better able to solve complex and subtle problems than less experienced younger people.

More people are living longer, healthier lives than ever before. Physical activity, work, and education are factors contributing to wellness — physical activity for the healthy body, education for the healthy mind, and work for both mind and body.

Brain research shows that an enriched stimulating environment results in an increase in brain weight, greater branching of dendrites, and an increase in glial cells, which provide support for nerve cells. The cerebral cortex also increases with use. It was found in animal studies that the thickness of the cerebral cortex increased as much as 16% in those from enriched environments. Exercise for the brain is as important as exercise for the body. Just as muscles atrophy from lack of use, so may the inactive brain.

In 1982 at the Healing Brain Conference in Tampa, Dr. Marion Diamond, Professor of Anatomy at the University of California, Berkeley, discussed her research which demonstrated that the brain can heal itself after injury if there is stimulation and activity. She also observed brain cell growth in later stages of the life cycle comparable to that which occurs in youth.

Educational Opportunities • Fortunately, there are many educational opportunities available to older adults. Florida, like other states, has recognized education as an important option. In the St. Petersburg-Tampa Bay area, which has one of the largest concentrations of people over age 60, junior colleges, community schools, and universities have programs for the mature student. In the private sector, there are many colleges which consider the older student a valuable addition to the intellectual community.

Elderhostel is an excellent example of a program specifically designed for people 60 and older. There are no additional requirements to attend. In the case of a couple, only one must be 60. Here we have an amalgamation of both private and public facilities.

This year is the 10th anniversary of Elderhostel. When the program began, six Northeastern colleges were involved; about 200 attended that first year. Today it includes 700 colleges throughout the United States, Canada, Mexico, Great Britain, Europe, and Israel. Approximately 100,000 students are expected to attend in 1985.

Two Tampa Bay area schools, Eckerd College and the University of South Florida, have Elderhostel programs. There are 12 participating colleges in Florida. Hostelers are offered a wide range of liberal arts and science courses. Such subjects as: "Speaking of Quarks and Quasars — Our Universe," "Ontogeny Recapitulates Phylogeny," and, of course, computers. These noncredit courses are taught by the faculties of the host colleges. Each session is for one week and includes three mini-courses. The cost of approximately $200 covers room and board, classes, and extracurricular activities.

Most Elderhostlers attend many times. One ageless lady has been to 14 sessions in the past eight years. She always goes with a friend and chooses a campus within two days driving time of her home. She reports, "Most of the students are professional people who have been involved in a lifetime of learning."

The people who attend Elderhostel have a spirit of adventure. They are not only looking for new things to learn, but also opportunities to travel. One of the reasons this program has been so successful is because there are thousands of older people eager to experience something out of the ordinary. Cheryl Gold, director of Elderhostel in Florida, believes that the hosteling experience tends to break down stereotypes. Young students, old students, and faculty get an opportunity to know each other on a common ground. Attitudes about youth and old age tend to disappear. Gold says, "In the seven years of working with Elderhostel, I have never met an 'old' person." The oldest student ever to attend Elderhostel was a 95-year-old man who came with his 75-year-old daughter.

Four years ago a bill was passed in the Florida Legislature that waived tuition for students over age 60, allowing them to audit courses at state universities on a space available basis. Lee Leavengood, Director of Mature Students at the University of South Florida in Tampa, reports that this year there are 263 students auditing courses, 94 of them attend classes at the Bayboro campus in St. Petersburg. Enrollment has increased each year since the program has been in existence, and 75% are repeaters, Leavengood says.

Dr. Maria Vesperi, Adjunct Assistant Professor of Anthropology, feels that the older students help set standards of achievemnent for the class. Thcy are more likely to contribute outside material to courses, inspiring younger students to do the same. They interact well with their classmates and with faculty, making their expectations known. These students, for the most part, display positive attitudes and realistic goals. Dr. Vesperi says her older students are a valuable addition to the academic community.

In addition to the waived tuition group, there are those who are working toward a dcgree. This year in the 45 to 65 age group there are approximately 1,300 students at the University of South Florida; those over 65 number 300.

One of these degree-seeking students is a 74-year-old woman. Responding to the question, "Why did you go back to school?" she says, "I didn't go back to school, I just continued going to school." She earned her first degree when she was 17 years old, then taught school until she married. During her married life, she lived in Italy, France and Spain, and went to school wherever she was. Several years ago she came to Florida. She had not been here very long before she began working toward a master's degree in French. She also serves as instructor in the Foreign Languages Department at the university.

One of the more innovative programs in the Tampa Bay area is the Program for Experienced Learners (PEL) at Eckerd College in St. Petersburg. A degree earned through PEL is the same as that awarded in the traditional four-year program. Eckerd requires that students complete 36 courses for graduation. The experienced learner can be credited with 27 courses based on past educational attainments and life experiences. For example, an Associate in Arts degree from a junior college is worth 18 courses or half the 36 required. In any event, everyone in PEL must complete a minimum of nine courses to graduate.

Course work in PEL can be accomplished in a variety of ways: directed study prepared by a faculty member, independent study developed by the student (subject to approval by a faculty member and the director of PEL), evening and weekend classes, most of which meet for eight weeks, five hours per

session. There are also tutorials, travel/study programs, and regular daytime college classes. With so many options, the student can easily arrange a schedule best suited to his particular lifestyle.

Dr. Gerald Dreller, Director of PEL, is impressed with the motivation of the mature student. He says, "Many of the PEL enrollees have already had successful careers. Some continue work in the same field; others branch out into something entirely different. Age does not seem to limit performance — most of the students over 60 graduate with honors." Dr. Dreller states that older people generally take on a greater academic load than their younger classmates.

A good example of a PEL graduate is a 70-year-old successful electronic engineer who came to Florida to care for his father, a victim of Alzheimer's disease. During this period he decided to change the direction of his life. He enrolled in PEL, chose gerontology as his major, and graduated with a 4.0 grade point average. Since graduation, he has been the director of a senior center near Clearwater.

The State of Florida also funds Community Instructional Services (CIS) which are administered by community colleges and county school systems. Approximately 18,000 courses are offered throughout the state. An estimated 500,000 to 600,000 are expected to attend this year. About one third are over 60 years of age. CIS classes are held almost anywhere: community college campuses, adult education facilities, senior centers, recreation centers, condominiums, mobile home parks, and any place there are enough people interested in taking a class. These classes are generally well attended; the size is limited only by the space available. Often it is necessary to repeat a class for those who were turned away the first time around.

Conclusion • Richard Bolles (1977), a work and life planner, sees life as divided into education, work and retirement. He feels that the ideal balance should be equal amounts of work, play and learning. Dr. Robert Butler (1975), the first Director of the National Institute on Aging, agrees with this concept and sees a need to think of education, work and play as running concurrently and continuously throughout life.

The older citizens of Florida are fortunate to have so many ways to keep mentally active. There is something for everyone. These seekers of wisdom and truth are typically alert, aware, motivated, and intensely interested in life. Unfortunately, "old" has had bad press, reinforced by geriatric studies which mainly look at the minority who are debilitated, indigent, or institutionalized. The time has come to recognize what older people can do rather than what they cannot do.

The patient with vague symptoms that defy diagnosis may be best helped by a prescription of "Back to school." Focusing on community concerns or how a computer works sure beats worrying about high blood pressure or the possibility of cancer.

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Alzheimer's Disease — a team approach to diagnosis and treatment

Shirley Cotton, R.N., M.N and Sharon Wodehouse

ABSTRACT: Alzheimer's Disease is a progressive organic brain disorder affecting memory, mood, personality and eventually physical functioning. Over 1.5 million Americans are victims of Alzheimer's Disease and it contributes to more than 100,000 deaths annually. Baptist Medical Center, Jacksonville, opened an Alzheimer's Center in August 1984. The center was established to serve the needs of the community, especially the aging community, by offering diagnostic services and personalized treatment for victims of Alzheimer's Disease.

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An estimated four to six percent of all people over the age of 65 suffer from Alzheimer's Disease, a progressive organic brain disorder affecting memory, mood, personality and eventually physical functioning. It is more prevalent among women, and victims have been documented as young as 40 years of age.

Called the "disease of the century" and the "silent epidemic," Alzheimer's Disease was first described by Alois Alzheimer (1864-1915) through an autopsy, which became the only way to confirm diagnosis. He found two brain abnormalities — an accumulation of abnormal fibers (plaque) and the appearance of tangled nerve tissue. These abnormalities appeared in the part of the brain associated with memory, judgment, concentration, speech, voluntary responses and other activities of daily living. Over 1.5 million Americans are victims of Alzheimer's Disease and it contributes to more than 100,000 deaths annually.

Various theories exist regarding the cause of this degenerative disease but the actual cause remains unknown as continued scientific studies investigate. The symptoms include mood changes, disorientation, denial, incontinence, violence, loss of speech and coordination, and eventual death, often due to complications of the disease itself.

Baptist Medical Center, Jacksonville, opened an Alzheimer's Center in August 1984. The center was established to serve the needs of the community, especially the aging community, by offering diagnostic services and personalized treatment for victims of Alzheimer's Disease.

The goals of the Alzheimer's Center at Baptist Medical Center are to keep patients healthy and living as normal a life as possible and to avoid hospi-

talization caused by preventable complications. Explaining and calling attention to the existence of the disease, which is often mistaken for "old age madness," is one of the most important aspects of the center.

One of only a handful of programs of its kind to be established in the country, the center is certain to become a model for others around the state and the entire nation for several reasons. Perhaps the most important of these is the need to understand the disease, on the part of the victims and their families as well as the general public, while treating the symptoms and helping to keep the Alzheimer's patient as healthy and independent as possible.

The first event planned in conjunction with the opening of the center was a community health education seminar to present information about the disease. On the day following the announcement of the seminar, over 70 calls were received. The next day over 250 calls were taken along with mail responses.

Due to limited space, two additional seminars were scheduled to accommodate the nearly 1,000 people who expressed the desire to attend. Following the presentation of the seminars, 75 requests for appointments in the center were received.

On August 21, the first two patients were seen. From this day through the end of 1984, 89 patients visited the center and over 60 percent were diagnosed as victims of Alzheimer's Disease.

More than a dozen of the patients, who ranged in age from 40 to 85, travelled over 100 miles to visit the center. Phone calls have been received from all over the United States as well.

The center offers a multidisciplinary approach to diagnosis and treatment. The team is composed of a neurologist, a neuropsychologist, and representatives of nursing services, social services and pastoral care. The family physician as well as physical therapy, occupational therapy and speech therapy, may also become involved in the patient's treatment.

There is presently no single diagnostic test for the disease. A battery of tests including a thorough comprehensive neurological and medical evaluation is necessary and diagnosis is made by process of elimination and based on clinical findings.

Patients are seen on an outpatient basis. The protocol includes an intake interview for social history with the patient, family and social worker. A nursing history and assessment is initiated by a registered nurse. The neurologist evaluates medical and neurological functioning. The neuropsychologist evaluates cognitive and functional abilities with the goal of management to maximize the "can do's" and minimize the patient's impaired functions. Further comprehensive studies include CT Scan of the brain (looking for infarcts, tumors, atrophy, etc.), EEG, blood studies (to evaluate metabolic and toxic dysfunction such as thyroid studies, electrolyte imbalance, vitamin deficiencies, lead poisoning, etc.). One purpose of such testing is to rule out other reversible causes of memory loss.

To assist in cost reduction, the center will accept results of tests performed less than one year before the visit.

After the testing and evaluations are completed, the entire team meets with the patient and family to discuss the diagnostic findings, offer recommendations for the future and assistance in long-term planning. The family is given a copy of the test results and interpretations for their records and a follow-up appointment may be scheduled in six months depending upon patient and family needs.

Another very important aspect of the comprehensive diagnostic approach of the center is that illnesses other than Alzheimer's Disease may be diagnosed. If other than neurological problems are discovered, rather than Alzheimer's or in addition to the disease, the patient will be referred to other specialists.

The team members remain available to the patients and to their families for continued assistance and support through a Family Support Group and counseling.

Those who are faced with the deterioration of their loved ones due to Alzheimer's are often puzzled, frustrated and frightened. They react with guilt, depression and, in rare cases, acceptance. One of the most helpful ways to deal with these problems is self-help support groups. Baptist Medical Center's support group was formed to help share solutions to the problems of managing the patient, to exchange information and to educate the community. The Family Support Group meets monthly, on the last Thursday of each month.

Caring for the Alzheimer's victim is very stressful and can lead to frustration, anger, confinement and depression for both the victim and the caregiver. Although the home is preferred as the caregiving setting, sometimes a family becomes unable to continue home health care. The decision to place a loved one in a nursing home is a difficult one to make.

When considering placement in an extended care facility (ECF), two of the most important considerations are the care and comfort of the patient and the financial feasibility of the move. Medicare will not pay for ECF placement when the patient requires "custodial" care. Victims of Alzheimer's Disease fall into this category. Medicaid, however, will assist in long-term placement if the patient is financially eligible for coverage.

The center provides counseling to assist the family with financial concerns (due to present insurance reimbursement policies, Alzheimer's Disease can be a financial disaster for patients and

their families) and practical suggestions for a realistic adjustment to nursing home placement when home care is no longer possible.

Evident from the high level of interest in the Alzheimer's Center, as well as from the number of patients who have sought the center's help, the program is filling a vital need. As the fourth leading killer behind heart disease, cancer and stroke, Alzheimer's Disease is finding its way into the public eye.

Bills are being sponsored in both the Florida Senate and House of Representatives (SB 121 and HB 77) regarding Alzheimer's Disease during the 1985 Legislative Session. The bills include proposals for: the creation of an advisory committee composed of seven members appointed by the Governor to make recommendations to the Department of Health and Rehabilitative Services; the creation of an Alzheimer's Disease Research Trust Fund; the provision of three HRS contracted specialized model day care programs to be located in Broward, Escambia and Duval Counties; and the provision of legislative funding for a memory disorder clinic at each of the three medical schools in Florida.

Study of these proposals and communications with state legislators regarding the importance of this legislation is extremely important.

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Role of acute care hospital in long-term care — a model program on South Miami Beach

Carolee A. DeVito, Ph.D., M.P.H. and William Zubkoff, Ph.D., M.P.H.

ABSTRACT: This paper focuses on promoting good health care for older persons through opportunities for assessment and planning in the community hospital setting and briefly describes organized efforts to achieve these goals on South Miami Beach.

Since 1980, South Shore Hospital has begun a transition to a model community geriatric health care center. Numerous activities — including a Model Discharge Planning Program, the Self-Care for Seniors Program, the Caregiver Training Program, the community-oriented Continuing Medical Education program — provided opportunities for collaboration between South Shore Hospital (SSH) and the Department of Family Medicine of the University of Miami (UM). A consortium, under the leadership of the hospital and medical school, provides mechanims to tailor services to needs rather than reimbursement as an integrated and coordinated health and personal care service system for the elderly. The mission includes mainstreaming the essential components of such a system into the usual activities of each provider while defining mechanisms to foster continuity among providers.

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Though it seems obvious that optimal health care for older persons should incorporate a long-term perspective, the potential roles of various providers in the health care delivery system have not been specified. This paper focuses on promoting good health care for older persons through opportunities for assessment and planning in the community hospital setting and briefly describes organized efforts to achieve these goals on South Miami Beach.

Long-term care needs • A description of "good" health care for the aged[1] includes an emphasis on restoration of functional ability, support systems, a broadened approach to health assessment and continuity of care. This patient-centered view calls for an emphasis on long-term care needs in relation to usual activities rather than limiting professional responsibility to acute episodes or specific diagnoses.

The extent to which our contemporary health care system, which reflects society's technological imperative, meets the challenge of long-term "caring" appears limited. For example, Medicare does not pay for prescription drugs outside the hospital, eyeglasses, hearing aids or a variety of outpatient and in-home services "even though such services may be effective in delaying institutionalization."[2] However, the need to address long-term care issues is obvious.

The State of Florida, and especially those communities with notably high proportions of elderly residents, face particular challenges. Among the estimated 2.02 million Floridians over age 65 this year,[3,4] "frailty"* increases from about 7% for the 65-74 year age group to over 40% for the 85 + year age group[5]. The community hospital may provide a unique opportunity to initiate responsive long-term

care programs because of its dominance in the health care industry as well as the high utilization rate among the elderly.

Brody and Persily remind us that there is no other community organization that serves more older persons than the community general hospital.[6] Older persons use the hospital at twice the rate of those under 65; about 20% of the elderly population is hospitalized each year. They are likely to have longer lengths of stay than their younger counterparts, and they are at risk for rehospitalization since the majority of their hospitalizations are attributable to chronic conditions. Thus, it seems reasonable to view the acute episode in the community hospital setting as an opportunity to respond to long-term care needs of the elderly.

The Department of Family Medicine of the University of Miami School of Medicine has joined a consortium of activities to address long-term care needs in the unique geriatric community of South Miami Beach, Florida. South Beach, the southernmost tip of the City of Miami Beach, is a catchment area of 3.03 square miles with a permanent population of about 40,000 (plus an additional seasonal population of the same size), approximately half the city's total population. The residents of South Beach are largely elderly and indigent: 60% of the permanent residents are over age 65 and 30% of households are below Housing and Urban Development limits for "Very Low Income." The problems of meeting geriatric health care needs are largely the same for South Beach as for other communities. But, due to the numbers of elderly, economic deprivation and geographic isolation, problems exist here in a blatant form. With its well-defined catchment area, South Beach has been dubbed a natural geriatric laboratory for developing, implementing and testing of approaches to health care delivery.

Community hospital services • South Shore Hospital and Medical Center is a nonprofit, fully licensed 178-bed acute care general hospital which is fully accredited by the Joint Commission on Accreditation of Hospitals. It provides community hospital services to the residents and tourists of South Beach. It is the only hospital located on South Beach, and it has the highest percentage of geriatric patients in the entire United States — over 90% on an inpatient basis with a median patient age of 79 years.

Since 1980, South Shore Hospital has begun a transition from a traditional acute care general hospital to a model community geriatric health care center. Numerous activities including a Model Discharge Planning Program, Self-Care for Seniors Programs, Caregiver Training Program, and community-oriented Continuing Medical Education program provided opportunities for collaboration between South Shore Hospital and the Department of Family Medicine of the University of Miami School of Medicine. An affiliation agreement was formalized early in 1982.

These programs and activities, plus future plans, were shared with community leaders with the aim of creating a system of coordinated services and developing mechanisms to insure access and continuity among all health and personal care services needed. The resulting consortium includes South Shore Hospital, University of Miami School of Medicine and the Geriatric Community Resources Steering Committee representing a full spectrum of services — nutrition, housing, day care, ambulatory care, and guardianship — as well as adequate political representation to facilitate activities.

The consortium, under the leadership of the hospital and medical school, provides mechanisms to tailor services to needs rather than reimbursement as an integrated and coordinated health and personal care service system for the elderly. The mission includes mainstreaming the essential components of such a system into the usual activities of each provider while defining mechanisms to foster continuity among providers — credibly passing the baton from the acute care setting to community-based providers.

The systematic identification of acute and long-term health care problems, the cost-effective matching of unmet health care needs with health care resources and services available on site or in the community, and the development of new programs where service "gaps" exist has become the primary organizational goal. Since needs assessment is the driving force for patient care, planning and program development, this approach dictates requirements of communication and cooperation among providers, service and payment coordination, efficient and targeted program planning and innovative or creative financing arrangements. The South Shore/University of Miami efforts to develop such a system are called the Geriatric Assessment and Planning (GAP) Program. The goals and a strong commitment to evaluation of program impact (costs and effectiveness) have resulted in two recent national awards:

The Robert Wood Johnson Foundation. South Shore Hospital and Medical Center is one of 23 hospitals in the nation, and the only hospital in the State of Florida, to be selected as a grantee in the RWJ Program for Hospital Initiatives in Long-Term Care.

W.K. Kellogg Foundation. South Shore Hospital and Medical Center is one of three national sites selected to participate in a large grant to develop asessment technology under supervision of the Burke Rehabilitation Center, New York.

*Defined as the percent of individuals who need help with basic physical activities or home management activities as well as individuals who usually stay in bed or need devices to control movements or urination.

These development grants provide the resources to institute the core of current activities, addressing the problems of less than optimal matches between patients' long-term care needs and services actually provided. The core activities can be described as intake and assessment, linkage to needed community-based services, monitoring the need-service utilization match and reassessment (Fig. 1). Specific organizational arrangements and tasks have been implemented to mainstream the core throughout the South Shore Hospital/University of Miami consortium providers, focusing on the inpatient stay as an opportunity to initiate and institute the most appropriate long-term care arrangements. These tasks can be summarized as requirements to integrate the comprehensive assessment system,* provide explicit mechanisms to assure linkage of patients through posthospital service providers, provide education and training for primary caregivers, provide patient education and service utilization information, reassess patients until community-based services are no longer indicated, provide patient education and service utilization information, and provide educational and administrative seminars for in-house and community providers. Additionally, patient assessments and utilization data are analyzed to identify major service gaps and explore mechanisms for the consortium to provide leadership in the development of needed services.

Numerous other activities are associated with the core:

Patient Care Services.

The listing of patient care services ranges from traditional inpatient/ancillary/ER services to in-home follow-up, self-care and caregiver training and geriatric rehabilitation to achieve a broad scope of patient care services that match this community's needs. The service implementation schedule was enhanced by a major expansion program. This included the construction of a ten-story, $12 million building adjacent to the existing hospital completed in May 1983, the first new construction on South Beach in nine years. This site provides the capability to house community health care and social service agencies, transportation service, and fire rescue. Both staff expansion and organizational restructuring have been necessary adjuncts to the patient care services.

The South Shore Hospital and Medical Center has served as host to related patient care services such as the Miami Veterans' Administration Adult Day Health Center and Miami Beach Development Corporation.

Cooperative activities also have developed: Co-sponsorship of a "Life-line" program with the Miami Veterans' Administration Medical Center and of the 12th annual meeting of the North American Primary Care Research Group ("Community-Oriented Health Care — A Brave New World").

Patient Information System.

The Integrated Patient Information System (IPIS) is designed to provide information necessary to support and advance the programs and services identified in South Shore Hospital's long-term goals and objectives. At the heart of the system are the patient data bases divided into three major segments: inpatient data files, ambulatory patient data files, and continuing care assessment data files. The system provides the capability of monitoring needs, service utilization (directly for on-site services delivered and through the GAP team and reports for off-site utilization), expenditures, quality of care, and functional status.

Professional Education.

Professional education activities at the hospital have evolved from traditional Continuing Medical Education (CME) to programs that reflect the development of this center as a model geriatric community health care site. These programs can be described briefly as:

The first clinical geriatric fellowship-physician training program in Florida jointly sponsored with the University of Miami School of Medicine and the Miami Veterans Administration Medical Center, began in 1982.

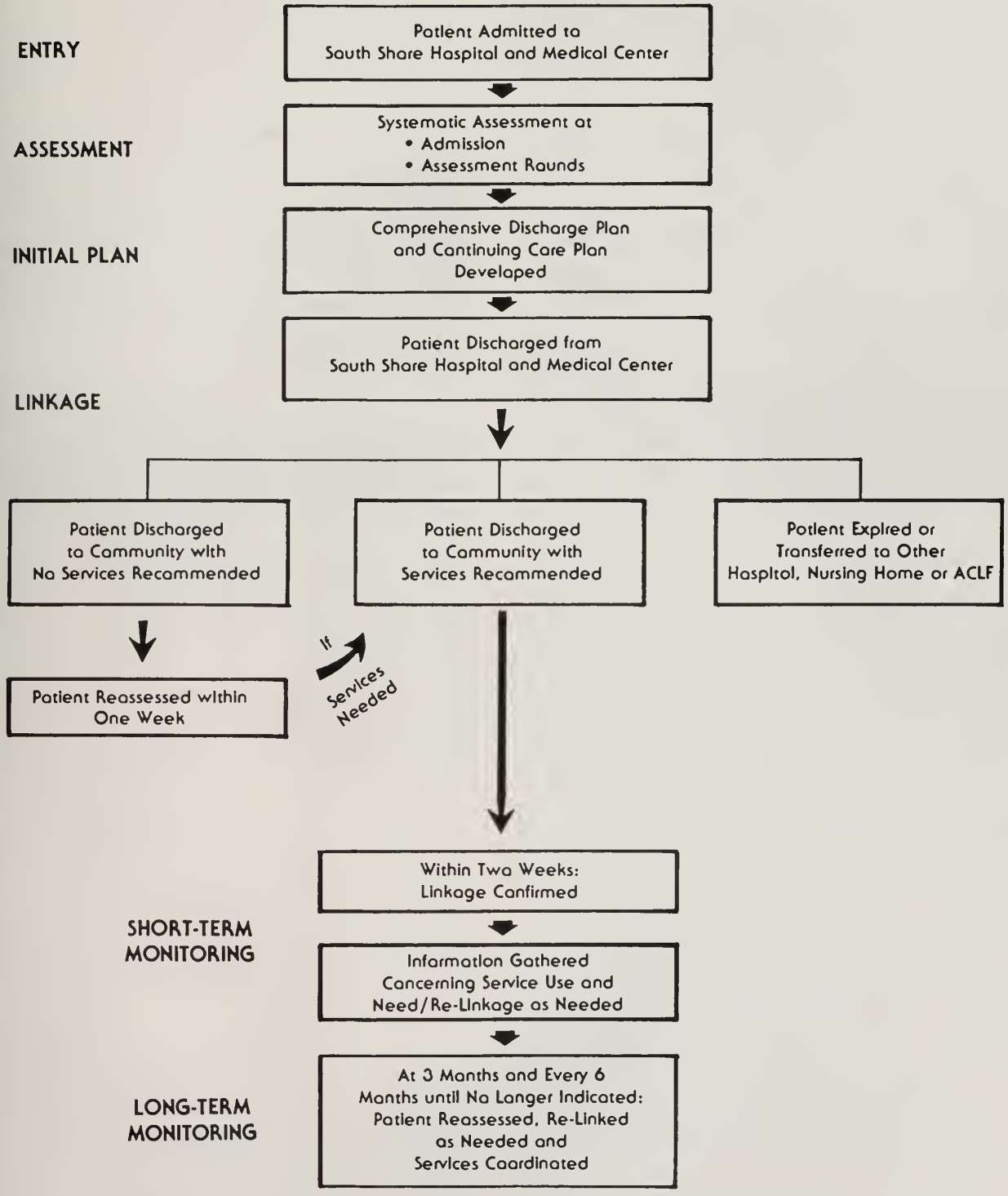
The Geriatric Nursing Program began in Sept. 1982 with consultation from the University of Miami School of Nursing to coordinate a geriatric in-service education program. The activities to date have centered on staff development programs that include department head meetings, a series of educational seminars with certificates and buttons awarded upon completion and designation of January as "Geriatrics Awareness Month."

Geriatric Outreach Education.

Patient education programs at South Shore have evolved similarly beginning with traditional diagnostic-specific instruction to a current array of senior citizen education programs which extend far beyond the hospital walls. The in-hospital Self-Care for Seniors Programs were adapted for numerous community sites. Similar "main-streaming" and outreach plans exist for the Caregiver Training Program. Other education/outreach activities include "Health Awareness" monthly programs, community presentations and co-sponsored events, monthly Alzheimer's Self-Help group meetings, twice-weekly Caregiver Support group meetings, Pacemaker Club and the Volunteer Training Program.

*Development of comprehensive assessment dictated the need for a functional health status assessment mechanism. Detailed assessment and monitoring of changes in functional health status began with the development of the Continuing Care Assessment Form (CCAF) in 1981. The CCAF has undergone many revisions and testing in the hospital. It provides a mechanism to record and monitor changes in functional status, medical status, and social support status. The CCAF includes measures representing nearly the entire Long-Term Health Care — Minimum Data Set (1980) and Michigan's Long-Term Care Information System (1981) as well as hospital-specific information.

Fig.1. — Pictorial representation of geriatric assessment and planning (GAP) program.



Program Evaluation and Research.

The Division of Research of the Department of Family Medicine, University of Miami School of Medicine, has been instrumental in the implementation of formative evaluation for programs initiated over the past several years with the Continuing Care Assessment Form as the basic data input.

Conclusion • The University of Miami/South Shore Hospital and Medical Center consortium has taken major steps to integrate the South Beach community medical, health, and social service activities philosophically and programmatically.

Though hospitals may be viewed as complex organizations representing hard-to-move bureaucracies, there are some clear benefits in promoting a comprehensive and coordinated system. These include increases in referrals resulting from expanded number and quality of services provided by the hospital, increases in revenues from an expanded patient population, diversification in revenue sources, decreases in numbers of administrative days for patients who can be placed more effectively, and decreases in problems with patient interaction attributable to training and education in geriatrics and gerontology. Further advantages include decreased interagency problems as secondary effects of the cooperation mandated by the various programs.

Of particular importance is the recognition by this consortium that rational and responsive health care delivery to older persons may be possible with major health care institutions as program initiators, but that community input and constant evaluation with a focus on patient functioning must drive the system of care.

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Megatrends in volunteering for and by the aging

Virginia Essex

ABSTRACT: Florida is experiencing unprecedented growth in its aging population. Challenges to respond to the unique needs of both the young-old and the old-old have been given to public, private and voluntary communities. Extensive networking by this triad has been taking place for the past two years. Progress is being made in development of well-managed, cost-effective volunteer programs involving the state's migrating elderly as well as local citizen retirees. Research and feedback from many sources have shown that there is a greater need than ever for volunteers and that people want to volunteer. There are those who are willing to sponsor and facilitate volunteer activities; in essence, the opportunity for development of voluntarism abounds.

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During the past 40 years, Florida's elderly population has grown elevenfold while the total population increased only fivefold since the 1940 census. This massive growth has prompted contemporary observers to articulate what is now rather commonly referred to as a "demographic imperative" (Committee on Labor and Human Resources, United States Senate, March 22, 1982). Simply stated, the tremendous increase in the aged population, relative to the population as a whole, presents a challenge to the State of Florida and its communities to understand and effectively respond to the unique needs of the aged. A plethora of data highlights the problems.

Florida is first in the nation in percentage of elderly 60 plus to the total state population (23.6%). Florida has 2.5 million elderly now and will have 3.6 million by the year 2000. Further, the 75 plus population has doubled in the last eight years and the 85 plus population increased 155.3% between 1970 and 1980.

Migration is a critical factor in the state's elderly population growth and composition. In 1979 one fifth of all residents 60 years and older had moved into Florida within the previous five years.

The average income of immigrants is one third higher than permanent residents and they are less likely to enter the labor force.

The longer term impact of the elderly "snowbirds" is negative; however, in terms of health and social service demands in the community because of a number of factors which lead to increased dependence.

In a recent needs assessment, the elderly were most concerned about health-related problems and the fact that they will need someone to care for them when they become ill or dependent.

Transportation is an important factor both economically and socially since only 52% of persons over age 65 have driver's licenses.

Within these data significant pockets of vulnerability exist, i.e., single females living alone, minorities and the old-old, all of whom tend to become more dependent.[1]

On September 29, 1980, Governor Bob Graham in an address to the 1980 Governor's Conference on Aging at Orlando pledged to marshal the resources of the state to meet the challenge of serving the rapidly growing population of elderly citizens. An inflationary and uncertain economy, reluctance of taxpayers to support increased federal spending, and realization that government is unable to provide all the money necessary to maintain diverse human service needs demanded that alternatives be sought. Since many organizations serving the elderly use volunteers to meet their goals and objectives, could expanded recruitment, training and utilization contribute to the enhancement of the quality of life for the elderly? The impact on cash containment could be substantial.

Voluntarism — philosophy or reality? • "Voluntarism is a cornerstone of the American way of life and a fundamental characteristic of our American heritage. The generosity and civic-mindedness of the American people have long been a noted aspect of our Nation. Since its inception, this has been a country in which neighbor has lent a hand to neighbor, and families have banded together to help one another in times of adversity. Greater emphasis must be placed on developing increased community commitment to voluntary service and on developing more volunteer leaders."[2] This statement from President Reagan's proclamation declaring 1983 the National Year of Voluntarism established a new theme and offered a partial solution to those struggling with budget cuts.

But where are these volunteers?

The 1983 Gallup Survey on Volunteering reveals that the total number of persons volunteering is 92 million, an increase of 3% over the 1981 survey (1981 — 52%, 1983 — 55%). So, slightly better that 50% of the American population volunteers. What can we say about the almost 50% who apparently do not? We can say it is time they do. Physicians can advise their patients to volunteer. There is great need to involve more people in volunteer programs for their own sake and for the good of their communities. Who knows better than the medical profession the healing effects of sharing time and talents with another person or a valued cause?

If, then, there is need to involve more people in volunteer programs for their own sake and for the good of their communities, why are our efforts not more impressive?

Several years ago George Romney spoke about the need of programs for voluntary action by the people through the "organization of voluntary effort." Regretfully, even at this moment in history when so many are aware of the importance of/and the need for volunteerism, our programs are not organized effectively. Why is it that frequently the position of Director of Volunteers is so often relegated to a part-time status? Why is not specific education and training for the volunteer manager a job requirement and why is the renumeration not commensurate with the person's abilities?[3]

If volunteerism is a vital component of public/private/voluntary partnerships, then many avenues must be opened to develop this profession. Both noncredit and credit courses in volunteer management are being offered in a few colleges in Florida. These courses should be widely replicated. It is no accident that the Association for Volunteer Administration is moving toward credentialing the profession through a certification program.

Clearly, if we are to accept the challenge of expanding and increasing volunteerism for and by the elderly, steps that must be taken will include: (1) strengthening the already existing programs by bringing together, organizing and coordinating their efforts, (2) bridging the existing gap between the voluntary sector, private sector and public sector, and (3) educating these participants in modern volunteer program management techniques.

The idea of using senior volunteers to augment social service delivery is not necessarily a response to the loss of funding. Volunteers will not replace those who have been cut back or cut out of the system. They are, however, a resource which lies within the population of this state. That population itself is aging, and the aging population is growing. In addition to utilizing the expertise of senior citizens in the areas of health care and social services, there will be many other areas such as consultants to business and to government, as educators, planners, and even critics whose experience in management may point out better directions.

In January 1983 the Aging and Adult Services Program Office of the Florida Department of Health and Rehabilitative Services received a grant from the U.S. Department of Health and Human Services and the Administration on Aging to develop the "Florida Program for Public/Private Initiatives for and by the Elderly — THE NETWORK." This program focused on creating or improving liaison between the public/private/voluntary sectors. Each sector was encouraged and aided at the community level to collect and share information, identify available resources, and develop and implement plans of action to fill the void created by budget restrictions. Many public/private organizations work for and with the elderly but they are unconnected except within categorical

or agency boundaries. It was evident that a network to support the activities of these different organizations was beginning to function but additional concentration, cooperation and orchestration was needed.

The expertise, skills and resources necessary to assist in the development and implementation of programs for the elderly were certainly available within the private sector; yet few efforts had been made to effectively connect private sector strength with public sector need. Could a plan be developed that would utilize those seniors who were willling to volunteer service to others and, at the same time, enhance the lives of those aged persons who had difficulty in caring for themselves? Establishment of THE NETWORK was not envisioned as the creation of a new organization or structure but as a process or mechanism for developing relationships between the diversified sectors, unifying efforts in seeking creative solutions to the identified issues, and maintaining communications through channels of a networking system. The concept of networking was certainly not a new one; yet its relevance and importance has come to represent an effective means by which to seek solutions to many emergent societal problems.

Conclusions ● Florida as a trendsetter for the nation is entering into a new era of experimentation, of new ways of meeting old needs, of new people involvement and more collaboration and cooperation between diverse groups.

A foundation on which to build good public/private/voluntary partnerships is in place. The voluntary agencies within the state are acutely aware of the need. They are eager to move forward to expand their services in collaboration with the private sector. The weakest link is the failure of the public sector to establish the necessary mechanism to supply what is lacking. Government entities, whether state or local, must establish credentialed volunteer programs that will clearly define the purpose and scope of their operation. When their level of commitment has been elevated to provide coherence and direction, assistance of business and industry can more readily be meshed within this structure.

Each component must know and understand each other's roles. All must work together in mutual trust and support. This may take time and require the services of an outside negotiator, but within this framework all can share knowledge and expertise to the mutual and healthful benefit of their communities.

The business and industry members of the NETWORK'S Public Sector Resource Group strongly encouraged and offered their personal expertise, as well as that of their companies, to the adoption of marketing management concepts by social service and nonbusiness organizations. There is evidence in recent literature that marketing to include not only goods but ideas, people and concepts is receiving wider acceptance.

The next steps must be to solidify a direct plan of action, to energize local initiatives, and to activate programs where needed. Together the public/private/voluntary sectors can achieve the goals of establishing systems that will provide a positive quality of life for the elderly of Florida in the most appropriate and cost effective manner possible.

Volunteering by our elderly and for our elderly offers hope. "For in the rejuvenation of voluntarism is proof that our best hope lies in something as simple as venturing forth from the comfort and familiarity of our own homes — and discovering who our neighbors really are."[4]

Editor's Note ● As used in this article, voluntarism is a philosophical concept referring to voluntary action by the private sector — those not affiliated with government. Volunteerism, on the other hand, describes the "people-helping-people process," organized or not.

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Caregivers of the demented elderly

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ABSTRACT: Dementia devastates not only the patient but also the family. Family members, usually a wife, daughter, or daughter-in-law, the major primary caregivers for those demented, are unprepared for the role which produces much personal and intrafamilial stress. We have developed and are testing a program termed Directive Training to improve knowledge about dementia and coping skills of family caregivers in order to provide better care for their demented relative and to determine whether this can delay or avoid institutionalization. Directive Training includes (a) information about dementia, (b) an approach to coping strategies, (c) knowledge of community resources, and (d) information about legal issues. Physicians who care for demented patients need to look upon themselves as diagnosticians as well as sources of information and support to family caregivers. This requires a knowledge of (a) dementing diseases, (b) available community resources, and (c) the types of problems faced by caregivers of the demented elderly.

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Among America's 23 million elderly, about a million (4.1%) have a serious cognitive impairment termed dementia. An additional 11% (2.5 million) have mild to moderate dementia.[1] It is the major reason for 60% to 80% of nursing home placements.

Dementia is not a normal concomitant of aging but indicates some underlying disease and demands careful medical evaluation.[2] Important causes of reversible dementia are drug intoxications, depression, and metabolic derangements. The cause in most patients, however, is usually Alzheimer's disease and less often multiple cerebral infarctions (multi-infarct dementia).

Families • For those demented elderly not institutionalized, the burden of care falls on their family.[3] Even when not totally dependent, demented elders need others for maintenance. The sad and frightening process of mental deterioration stresses and can divide the older person's family. Contrary to popular belief, families do not abandon their failing elders but rather make up the largest group of caregivers.[4] The importance of the family cannot be overestimated. As dependencies increase, so do interactions with the family.[5-7] Emotional support, nurturance, and intimacy — elements that become more critical as the impaired elder becomes less independent — can only be offered by the family. The family directly affects the quality of the demented elder's life.

Unlike recognized physical ailments that affect the elderly, cognitive impairment is insidious and engenders much misunderstanding and intergenerational conflict.[8] The inability of families to manage behavioral problems in demented relatives is a major cause of stress in caregivers and is the major reason

leading to institutionalization of the elder. The increasing demands of failing elders on relatives leads to resentment and emotional conflicts[9, 10] and at times to neglect and abuse.[11]

Most caregivers are spouses or adult children, supplemented by other family members. A spouse will usually serve as the primary caregiver for as long as possible. If the spouse is no longer living a middle-aged child is likely to be the caregiver. Nearly as many children are primary caregivers as are spouses.[3]

Primary caregivers usually are women (70% to 90%). Since women live longer than men and wives usually are younger than their husbands, the wife often serves as caregiver. Adult children who serve as primary caregivers are most often daughters or daughters-in-law. Since many women work, they assume the role of both worker and caregiver. The caregiver role is added to those of wife, homemaker, mother, and worker, increasing the stress placed on these women.[3]

Relatives become caregivers for many reasons: out of a sense of obligation; in order to repay parents for what they have done; the desire to care for an elder at home rather than placing him or her in a nursing home; and in an attempt to assuage guilt over past events.[3] For the most part, families are not aided in their efforts to care for their aging relatives. Families have a poor understanding of dementia. Physicians have not served as a source of support or information.[12] Seldom is the focus on the family even though aging is a family affair.[13] There are few services available to assist the family in handling day to day problems accompanying the increasing demands on time and energy that result from caring for a demented elder. Adult children are not provided with the assistance needed in their struggle to care for old people. They generally lack information on what to expect in terms of physical and emotional demands that will occur in caring for a relative with increasing intellectual impairment and they have limited knowledge of community resources that might make their task easier. Home-based community care depends on the availability of social support to the family. But it seems that family caregivers are often ignored in the combination of services to the elderly which have as their single focus the impaired person and not the social milieu in which this person functions.

Most family caregivers need help in learning to assume the role. There is no preparation in our society for this kind of role with its duties, stress, and frustration. No description or expectation for the role exists.[3]

The likelihood of institutionalization is markedly reduced if a demented elder has a caregiver in the family. A British study[14] of 83 demented persons living in the community showed that after a year of observation, 70% were either dead or institutionalized (30% and 40% respectively). The cardinal factor affecting viability in the community was family support. Forty-six percent of the demented elders living with their children remained as community residents after a year. Those living with their spouse did not fare as well while those living alone had the poorest outcome.

Support groups • Support groups for relatives caring for the demented elderly in the community have sprung up in response to a need.[12, 15] These groups provide a forum for discussion and support. They are economical on professional time, supplement other types of support, provide information, and allow sharing of practical experiences in coping. The experiences of these groups indicate common themes that need to be emphasized in developing support programs. The groups are felt to benefit relatives and to act as an important treatment aid to the demented elderly.[12, 15] The reported benefits of group participation are better understanding of dementia, more appropriate expectations, less guilt, anger, and frustration, a sense of support, and less isolation.[12]

Directive training • With a greater knowledge about dementia, what to expect, and how to approach problems, the family might experience less stress, cope better, use available resources more fully, provide better care for their demented relative, and hence postpone or eliminate institutionalization. The demented elder also would profit from receiving improved care in a familiar setting and thus tend to diminish dependency and delay institutionalization. Although the number of support groups for relatives are increasing, no controlled scientific evaluation of their impact on caregivers, the demented elder, or the rate of institutionalization has ever been undertaken. Our aim is to fill a gap by scientifically assessing under controlled conditions the impact of a support group on both caregivers and the demented elder by quantifying psychologic effects and any alterations in the pattern of institutionalization. We term our technique of combined information relevant to aging and the caregiving role and emotional support Directive Training; simultaneously the family is given emotional support, shares its problems, feelings, and solutions, and is provided with information about dementia and how to approach and care for the demented person.

A. Dementia • First, an overview of dementia is presented. Dementia is defined and symptoms are described and explained so that caregivers will realize that behavior that may be interpreted as willful or contrary (such as refusing to dress) may represent a lost ability. The causes of dementia are reviewed and the need for a careful medical evaluation is stressed. Dementia can be transiently worsened by many fac-

tors such as illness or change of environment. Treatment is approached from three facets. First, although no specific therapy exists for progressive dementias, e.g., Alzheimer's disease, remarkable progress in approaching this problem has occurred in the past few years and one should not lose hope of some beneficial approaches being developed in the not too distant future. Second, demented persons with so-called irreversible dementia can have improvement in their cognitive function if other medical problems are treated.[16] Treating cardiac and respiratory disease can improve general function and intellectual ability. We all do better when we feel better. Third, emotional problems that often accompany dementia are often readily amenable to treatment with psychoactive drugs. Many demented elders with emotional difficulties can be markedly improved with the judicious use of appropriate medicines.

B. Coping • An approach to coping with the disordered behavior of the demented elder presents a description of behavioral problems, caregivers' reactions to these, coping mechanisms, and hints from those present who have faced these problems. A list of frequently encountered behavioral difficulties is presented (Table 1).[15, 17] Reactions to stress of caring for the demented elder (Table 2) are enumerated.[12, 15, 17, 18] The effort is to indicate that these are understandable responses and occur to varying degrees in all caregivers. Coping mechanisms and approaches to problem behaviors are discussed. Lastly, hints, solutions, and approaches are shared (Table 3).

A list of books directed at providing caregivers with information and insight in caring for the demented person is given (Table 4).

In addition, caregivers are instructed in how to better use the medical care system. It is suggested that their demented elder have a thorough and careful medical evaluation looking for the cause of dementia which in a minority of cases might be completely or in part reversible, and to detect other medical problems which when treated might lead to a better state of health and secondarily to improve cognitive functioning. Many doctors, unskilled in geriatrics, mistakenly think that demented elderly patients cannot be helped. This leads to despair on the part of the caregiver.

In order to make doctor visits more productive, caregivers are urged not to rely on memory but to bring in all medicines at each visit. They are instructed to be precise and to write down specific medical complaints or questions. Lastly, the caregiver must not hesitate to tell the doctor if medical advise is not completely understood. If instructions are not clear, whether coming from a physician,

Table 1. — Problem Behaviors in Demented Elders.

- Memory Loss
- Communication problems
  - Expressive aphasia
  - Trouble understanding
- Confusion and disorientation
- Not recognizing caregivers
- Waking at night
  - Interrupting caregivers sleep
- Wandering (day or night)
- Problems at mealtimes
- Falling
- Inappropriate sexual activity
- Incontinence (urinary or fecal)
- Repeated questioning or activity
- Crying
- Negativism
  - Resistance to care, e.g., bathing
  - Arguing
  - Critical, demanding behavior
- Aggression
  - Angry outbursts
  - Hitting
- Emotional lability
- Catastrophic reactions
  - Strong emotional outburst due to not being able to perform a task
- Paranoia
  - Suspiciousness
  - Accusations
  - Hiding things
- Delusions
- Hallucinations

Table 2. — Caregivers Reactions to Stress.

- Anger
- Resentment
- Frustration
- Feeling trapped
- Isolation
- Depression
- Guilt
- Fatigue
- Ambivalence toward demented elder
- Family conflict
- Concerns over money
- Difficulty assuming role of caregiver
- Loss of self-identity
  - Lack of time for self
  - Loss of friends
  - Loss of time for pleasurable activities
- Worry about becoming ill
- Worry about demented elder's behavior

Table 3. — Suggestions for Coping with Caring for Demented Elder.

1. Get assistance from others
   - Accept help when it is offered
   - Ask family or friends to help when necessary
   - Hire someone if you need to
2. Get needed rest
   - Assure sleep
   - Take off an afternoon or night each week
3. Maintain social contacts
   - Go out with a friend
   - Continue hobbies, participation in organizations, and other pleasurable activities
4. Do not expect to get much done; caregiving is time consuming. Pace yourself accordingly
5. Develop strategies to deal with unpleasant behavior
6. Do not feel guilty about getting angry at demented elder
   - Caregivers are not saints
   - The demented person will not remember the incident
7. Accept that the demented elder will not get better
8. Seek out a local support group
   - Realize you are not alone
   - Increase ability to cope
   - Shared feelings and problems
   - You can help others

Table 4. — Books About Caring for the Demented Elderly

Mace, N.L.; Rabins, P.V.
The 36-Hour Day
Baltimore, The Johns Hopkins University Press, 1981

Reisberg, B.
A Guide to Alzheimer's Disease:
For Families, Spouses, and Friends
New York, The Free Press, 1981

Powell, L.S.; Courtice, K.
Alzheimer's Disease: A Guide for Families
Reading, Massachusettes, Addison-Wesley Publishing Co., 1983

Weston, L.L.; White, A.
Dementia - A Practical Guide to Alzheimer's Disease and Related Illnesses
New York, W.H. Freeman and Co., 1983.

nurse, pharmacist, or other health worker, the caregiver must ask for a repeat explanation until it is clear.

C. Community resources • A list of community resources that may be helpful is provided. These will vary from one city to another but included are day care centers, respite services, home health aids, sitters, community groups, services provided by the Older Americans' Council, etc. An explanation of what Medicare does and does not cover is presented. How to apply for disability for the demented elder is explained. Eligibility for Medicaid and food stamps is presented. The Alzheimer's Disease and Related Disorders Association (360 North Michigan Avenue, Chicago, IL., 60601) is a national organization with local chapters and support groups. It publishes a bulletin and has listings of affiliated support groups.

D. Legal issues • Legal issues are important, complex, and vary from state to state. Topics covered are power of attorney, competency, guardianship, financial matters, wills, and inheritance. This is a particularly labyrinthine area requiring the assistance of a knowledgeable attorney. Since the problem of dementia has only recently become recognized as a major issue, many existing laws are not written in such a manner that they approach or hit upon crucial areas in what is needed to both protect and care for the elderly.

Conclusions • Physicians need to increase their awareness and sensitivity about dementia and must be familiar with approaches to diagnosis and management. Family caregivers are the crucial element in the care and maintenance of demented persons in the community. Physicians need to provide information and support to caregivers and make themselves knowledgeable about community resources, especially Alzheimer support groups.

Communities need to examine the needs of their citizens in relation to this common and devastating problem. Not only government (federal, state, and local) but also churches, service organizations, and volunteer groups can do much to improve the lot of both caregivers and demented elders.

The directive training sessions punctuated some important aspects. Caregivers appreciated the information given and considered it valuable. Suggestions for coping were highly regarded. At the same time, caregivers felt trapped by a lack of interest and concern for the demented elder and the caregivers as manifested by sparse community resources (such as sitters) and particularly by a system of payment for services that essentially ignored dementia and required that the demented elder (and often the spouse) needed to become impoverished before any program assistance was available. The legal code that impinges on the problems of demented elders was not designed for the difficulties faced by this appreciable segment of our elderly population. Pertinent laws need to be examined and legislation drafted that is more in concert with current needs.

The information and support provided by Directive Training have been beneficial to caregivers. In addition, the process has emphasized fiscal and legal

inequities that can be corrected through legislative and policy changes. A clear need exists for care programs, more appropriate entitlement programs, and clearer legal processes.

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On death and dying

Clyde M. Collins, M.D.

Death Comes to the Physician

Who speaks thus —

"Enter Death, my old acquaintance! I will not call thee friend, for we have been adversaries these fifty years. Success at times has been thine, and failure likewise — when victory has been mine. Neither can I deem thee wholly evil, for at times thou hast brought surcease from suffering to those whom my poor skill could not ease. When the shadow of thy presence hovered over those whom thou didst not touch, was this to test the mettle of their soul or to challenge me to greater endeavors? Thou dost not answer?

"So thou has come for me. I know thee too well to fear thee. Come, let us walk arm in arm down the long corridor until I enter the portals of eternity, from whence thou art forever barred."

—James C. Thoroughman, M.D.
1904-1972

The Author

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How do I find a good doctor that I can afford? How do I talk to him and how do I get him to listen to me? How can I be sure that he is basically kind and deeply concerned about his patients? These are fears of our aging population, and in planning any program of medical care for them, only we, the physicians of Florida can supply the answers. While the primary care practitioners, more specifically, serve as advocates for the aging population, all of us should assist in informing and supporting our older population for the enhancement of their lives. Often rejected by their families and overlooked or ignored by our profession, the aged, will if given the opportunity, realistically talk about many things; their rights to health and happiness, their rights to live or their rights to die. They would like to know whether they need a living will, if they have a doctor who would be honest with them and in whom they trust. Their anxiety is that they fear the media-reported excessive use of life sustaining treatments during their final illness. If we will just listen, we can learn about the strengths and weaknesses of our present system of care from them.

In planning treatment for the terminal days of a life threatening illness one viable alternative to traditional acute care has been the Hospice concept, an innovative approach to caring for the terminally ill. This concept is centered on the belief that terminal patients, in order to spend their final days in peace and dignity, are better served in the familiar surroundings of their own home, or rarely when necessary, in a comfortable Hospice inpatient facility. The critical component of Hospice care is the delivery of services by an interdisciplinary team of physicians, nurses, social workers, therapists,

clergy and specially trained volunteers. Approximately 1200 programs are in operation around the country, utilizing thousands of professionals and trained volunteers, and since November of 1983, Hospice benefits are reimbersable under Medicare.

In the index of Dr. Kubler-Ross' book, following the chapters denoting the 5 stages of the patient approaching death: "Denial and Isolation, Anger, Bargaining, Depression and Acceptance" is one entitled "Hope." This may be unrealistic for the patient, but not necessarily unobtainable. Hope for a miracle, a new drug, a last minute reprieve, creates an optimism that has maintained the terminally ill through days and weeks of suffering. It is their daily prayer that all this has some meaning, giving them a sense of a special mission in life which helps maintain their spirits that they may live a little longer than expected. Patients in the terminal stage of an illness are often morbidly uncommunicative and depressed. Much harm can often be done by forcing the discussion of death. Neither is avoiding the issue beneficial, but an unhurried visit where the doctor takes time to sit, listen and share, allowing the patient to understand that he will take the extra time when he, the patient, feels like talking, brings much relief to many patients and helps them to share their concerns. Family members and the medical profession need to become more sensitive to the implicit communications of dying patients so as to help the patient get in tune with his family. Both need to come to the acceptance of an unavoidable reality together. This will help to avoid much unnecessary agony and suffering on the part of the dying and even more so on the part of the family.

One way to avoid thinking about death is by concentrating on the details of every day life while, conversely, thinking about death can make life's details so unimportant, that they become a burden or too much trouble to think about. To a patient in pain this produces a vicious circle which contributes to his or her depression. Yet in the face of all this the terminally ill continue to live and need psychological support in confronting the pain, weakness, depression and loneliness.[2] We cannot look at the sun all the time, neither can the terminally ill face death all the time. At times he or she will be able to consider the possibility of death, but much of the time this consideration must be put away in order to pursue daily living. A healthy way of dealing with this uncomfortable and painful situation is denial, which functions as a buffer, and the need for denial exists in every patient at times. To some, denial is necessary in order to remain sane.

Good communication between the doctor and the patient, concerning a bleak prognosis should produce a challenge not despair, hope not emotional devastation and a patient-physician bond rather than a sense of abondonment. Chaplains, social workers and clinical psychologists with vocational skills, largely verbal, all do an excellent job at this stage in the life of patients. Along with this, physicians should physically touch their patient, especially when cure or control is impossible. Healing is more than curing. By touching elderly patients, the physician symbolically honors their pilgrimage through 80 or 90 years. His hand on the shoulder or arm reinforces his words or if silent, his sustaining presence and is a reassurance that the patient will not be abandoned.[3]

Over the years, formulation of universally accepted guidelines for treating the hopelessly ill has remained difficult. In caring for the irreversably ill adult, consideration must be directed at two important concepts: the patient's role in decision making is paramount and a slackening in aggressive therapy is in order when this would only prolong a difficult and lingering death. Past experiences, education and training of the physician emphasizing positive actions to sustain and prolong life make it difficult to accept a concept that it may be best to do less, not more for a patient; and to say "no" to further therapeutic measures. "Technology competes with compassion, legal precedent lags and controversy is inevitable."[4]

Hospice is a new and challenging opportunity to refocus on the patient as a human being. To doctors and nurses it can be a mutually gratifying experience with its program to give each patient a chance for living. Hospice does not give up on any patient, "terminal" or "not terminal", but exists to provide living. Hospice does not give up on any patient, 'terminal" or "not terminal", but exists to provide palliative care when curative measures are no longer in the patient's best interests. In palliative care the emphasis shifts so that technical procedures are minimized and the role of the care givers is expanded both in terms of time and personal attention. The overall goal is to provide a physical environment that is therapeutic in itself. Patients need reassurance that everything possible has been done, and that they will not be abandoned, but when and if new treatments become available, they will be offered to them. Hospice exists to allow each patient to maintain some manner of independence, to strengthen the relationship of each patient with his doctor, to support the family as a unit, and to provide a little time to be happy, to celebrate an anniversary or a birthday and to have a few pain free hours to get his or her affairs in order. For the many whose religion teaches them that there is another world beyond the grave, where their immortal soul will reside, perhaps the method of the ending of their life is its most important act.

"And what is as important as knowledge?" asks the mind.
"Caring and seeing with the heart," answered the soul.

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What Florida's elderly need from the medical community

Mrs. Anne Swing

Because of its knowledge, expertise, and dedication to optimum quality of life, the medical community is in a position of obligation to those it serves. Florida's elderly need certain responses from physicians. In many instances, the doctor is the main person upon whom the older patient depends for advice. Countless elderly Floridians are alone, cut off from friends and relatives. They may have undergone the trauma of relocation and now face the unknown difficulties of aging. No one can be everything to all persons, but it behooves Florida physicians to take a careful look at doctor-patient relations, as they concern the elderly. Since Florida has the largest percentage of older adults in the United States, senior citizens are a primary consideration. Issues related to health care mount daily, in geometric progression. Speedy response is of the essence. The period for philosophizing is past; the time for action is at hand.

Older persons need understanding from their doctor. The medical practitioner and his/her staff must perceive each senior citizen as an individual — the same person he was when younger but encumbered by symptoms of aging. Stereotypical thinking is non-productive. It inhibits clear insight to the older patient's true condition. His seeming rejection of medical advice is usually rooted in an intense fear of the unknown. On a fixed income, he worries about financial ability to pay for health services. He is concerned about loss of agility and endurance and dreads the possibility of becoming incapacitated or dependent. It is not uncommon for an older person to become withdrawn and isolated. Because of inadequate transportation facilities, physical limitations, and disruption of routine, a visit to the doctor's office may be an event of major proportion in his perception.

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The mature adult usually responds quite favorably to respectful treatment. He is a person with a lifetime of knowledge and experience, deserving dignified reception. Respectful treatment usually breeds respectful response. The older adult is likely to accept advice and direction from one who shows him courtesy. He is more inclined to share his feelings about physical and emotional concerns with one who demonstrates genuine respect for those feelings.

The older person needs to feel secure about his physician. He may need to visit more than one doctor; however, it is essential that the primary care physician carefully coordinate the total health care regimen. This particular practitioner should understand the patient's living conditions, family role, obligations, stresses, and any other issues which might affect his health. The doctor may be the only person with whom the patient comfortably entrusts confidential information. With a sympathetic physician, he can face physical problems within the context of his particular environment and responsibilities, thus making realistic adjustments and intelligent decisions. The patient who helps plan his treatment is more likely to follow closely the doctor's recommendations.

Even though a physician is extremely busy, it is to his advantage, and that of his older patient, to take ample time to explain any treatment, procedure, or medication he prescribes. This will ensure understanding of directions and help prevent confusion. Doctors should use whatever explanatory means are most appropriate. The "Medi-File" card, printed by the Florida Medical Association, promoted by the FMA Auxiliary, and issued to older patients by FMA physicians, is designed to prevent drug misuse by providing a wallet-sized instrument where each physician the patient visits can list medications prescribed. This is one concrete example of the medical profession's concern for patient welfare. The possibilities are endless.

One of the latest trends in senior living is the mainstreaming concept. Real estate experts have recognized the need to provide a broad spectrum of housing options for the elderly including retirement hotels, congregate living facilities, specially designed apartments, and retirement villages which allow older adults to remain active participants in community life. The medical profession should facilitate this mainstreaming effort by promoting community centered health care. All agencies concerned with caring for Florida's older citizens are looking to physicians to play a primary role in spearheading this movement. Existing programs need to be identified and coordinated and gaps effectively filled. Under this system, doctors would recommend home health services or institutional or hospital care as needed. Ideally, the patient would be able, by phone, to reach his physician, or a delegated professional, to answer health questions between office visits. By its very nature, the hospice concept is compatible with the idea of community centered health care. The ultimate goal would be for as many senior citizens as possible to remain independent, in their own homes, while still being able to obtain essential health care services.

Challenges to Florida physicians for improving the life of our elderly are formidable. They will be met, however, because the Florida Medical Association, its members, and the FMA Auxiliary are cognizant of the immediacy and vital importance of these issues.

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Involuntary guardianship: panacea or bitter pill

Dale J. Hyland, R.N., B.A.

ABSTRACT: Guardianship represents an interdisciplinary concept involving legal, economic, medical, and social issues in every phase. The problems surrounding its application may often be traced to this being misunderstood or ignored. Guardianship is not an emergency procedure nor is it a first resort. It is restrictive for the individual and can create more problems than it solves. It impacts on the very essence of family structure and interpersonal relationships. This paper presents the issues of competency and guardianship from an interdisciplinary perspective. The benefits of this approach to the physician, attorney, court, and family, but most importantly to the patient-client who may become the subject of competency proceedings, will become evident.

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The notion of sanctioned controls over individuals and their property has deep roots in antiquity. During the Roman era persons believed to be incompetent were brought before a jury which decided the competency question. The process became refined in the Middle Ages and, as an outgrowth of English common law, the concept of *parens patriae*—the king as father—emerged. Under this system the king through his designees took custody of the incompetent's property, and the person was maintained with the income from the estate.[1]

The principle of *parens patriae* filtered into American jurisprudence becoming in effect the "state as parent," and formed the basis for incompetency declarations and the appointment of guardians. Most states have statutes providing for the appointment of a guardian or conservator for individuals who lack the capacity to care for themselves or their property.[2]

Contemporary practices • Preliminary to a petition being filed with the court to determine competency, an informal decision has been made that the individual lacks capacity and requires assistance. Petitions may be brought by relatives, neighbors, agency staff, or others concerned with the welfare of the alleged incompetent. Frolik[3] identifies several recurring conditions which precipitate requests to determine competency: A potential ward is about to inherit a substantial amount of money; he is not caring for himself or his dependents; there is a fear that he is being or will be victimized or he is likely to dissipate his estate. In addition, a guardian may be sought either when a doctor withholds medical treatment due to the belief that the patient is incompetent to provide informed consent, or when relocation is desired such as admittance to a nursing home. Whenever there is a desire to relocate an uncooperative or

incapacitated adult, it is probable that a guardian will be appointed. High risk groups likely to become subjects of competency proceedings, according to Gutheil and Appelbaum,[4] are: acutely psychotic patients, chronically institutionalized patients who have lost the capacity to evaluate proposed actions or interventions; patients with organic impairment, often elderly; depressed patients who show impaired reasoning; the mentally retarded; and patients who are being asked to consent to risky procedures or procedures with little hope of direct benefit to them.

The incompetency/guardianship process in Florida is similar in many respects to those in other areas of the country. Once the initial petition is filed in the probate division of the circuit court, a hearing date is set and an examining committee is appointed consisting of one responsible citizen (layman) and two practicing physicians. This committee then proceeds to examine the alleged incompetent to ascertain his mental and physical condition. If the examining committee considers the person under examination to be incompetent, it determines his age, whether his condition is acute or chronic, and the apparent cause of the condition.[5] In this regard, it is interesting to compare statutory provisions in California. These statutes look solely to a behavioral criteria, the cause of the behavior being irrelevant: "Functional inabilities means . . . the person is unable properly to provide for his own personal needs . . ."[6] The Florida examiners' report is to be signed by each member of the committee and transmitted immediately to the court. If the report of the examiners is that the alleged incompetent is not mentally or physically incompetent, the court dismisses the petition.

Typically, competency hearings are informal and nonadversarial, lasting only a few minutes. The proposed ward is not present nor represented by counsel. Petitioners may or may not attend and the medical information is communicated to the judge on a standardized form. Potential guardians are often relatives who may also be the petitioners for the incompetency and will be represented by counsel, the attorney of record. If adversarial elements are introduced, they usually surround controversy over who should be appointed as the guardian. Since Florida law prohibits an adjudication of incompetency without the appointment of a personal guardian,[7] the hearing to determine competency is usually immediately followed by the appointment of the guardian. Within the context of the traditional competency hearing it is unlikely that any meaningful client advocacy will enter the process.

Consequences • For the individual placed under plenary, or unlimited, guardianship significant rights are suspended for the duration of the incompetency status. While ownership is retained, the management and control of funds and assets are given over to the guardian/conservator. The incompetent cannot make gifts or contracts, marry or divorce, enter into joint tenancy or tenancy by entirety, create a trust, change beneficiaries of his insurance policies, or choose his residence.[8] He cannot retain a driver's license, provide informed consent for treatment and, in short, forfeits the right to liberty and self-determination.

Guardianship is not the panacea perceived by some nor the anathema argued by others. It is intrusive; it can be abused, but it can protect the ward, preserve his assets, prolong his life, and provide continuing supervision and care when the individual is unable or unwilling to responsibly care for his own needs. Moreover, guardianship should maintain a measure of dignity and self-esteem in the individual beset by overwhelming difficulties with which he is ill-equipped to deal.

Problems with a guardianship may occur when the process is used prematurely, when a less restrictive form of intervention and control could have been utilized. At times, inappropriate reasons for petitioning for legal guardianship include an excess of therapeutic zeal which leads to the wish to take over and control the patient by these legal means and the desire to coerce, take advantage of, or bypass the individual as an active participant in decision making. The latter point may understandably result from a wish to deal with a rational person since the patient's irrationality is so frustrating.[9]

The likelihood of benefit to the individual is the most cogent criteria for pursuing guardianship. Yet, the guardian is not a miracle worker nor will the creation of a guardianship reverse any obstinate tendencies in the ward. In many ways the cooperation of the ward is inherent to the success of the guardian's efforts on his behalf.

The enticing short-term benefits of guardianship for the multiproblem patient may overshadow the potential problems which often develop in the long run. This will frequently occur when the immediate objectives are dramatic, easily identified, and meet the needs of significant others concerned with the individual's life and affairs. In a sense the patient's needs and rights may easily be relegated to a low priority by expediency, financial considerations, and institutional procedure.

Conflicts of interest often occur when family members assume the role of legal guardian. Their emotional involvement may create stresses and family discord which can degenerate into permanently divisive forces. Issues of domination and the preservation of inheritances will often create a climate unfavorable for true advocacy and decisions which are in the best interest of the ward. For the novice family guardian, discovery of unforeseen complications with assets, frustrations encountered in interacting

with service-delivery systems, and necessity of formal accountability are likely to discourage the most devoted relation.

Because of the significant sociolegal consequences for the individual, the decision to pursue competency hearings must always be made carefully and after full exploration of workable alternatives. One solution might be to seek protective placement in a boarding or retirement facility, adult foster home, or institutional setting. A second option would be to obtain a representative payee to handle benefits such as Social Security, veteran's and pension checks. Case management services, available in many communities, would offer professional follow-up for the potentially "at risk" individual. Finally, the durable power of attorney, a legal device created to endure beyond incapacity and disability or to only become effective when factual incompetency occurs, offers a viable option to guardianship of property.[10]

Scope of concern • In 1982 the Florida Bar sponsored a study of the legal needs of disabled people in this state. Among attorneys and human service providers questioned, competency and guardianship issues were consistently given high priority.[11] More recently the Florida Committee on Aging in its final report to the governor made several related recommendations. In addition to the need to develop a systematic program to integrate social, mental health, and physical health programs, the Committee charged the Florida Bar with developing "judicial safeguards for elderly persons facing guardianship . . ." proceedings. The need to legislate a comprehensive guardianship program for the indigent elderly was also cited in the report.[12]

In some respects the nonadversarial nature of the guardianship process in Florida and elsewhere is the cause of confusion, inconsistency, and disparate views regarding a "proper" role for attorneys within the process. Even when the proposed ward is represented by counsel, the outcome is likely to be ceremonial rather than efficacious. This gives rise to rampant paternalism throughout the system and renders the proceedings "subject to a large number of apparent due process deficiencies."[13]

The common absence of counsel for the alleged incompetent is generally viewed as unfortunate. The routine application of a "best interests" standard in competency proceedings has promoted the acceptance of procedural informality, relaxed rules of evidence including the free use of hearsay, and the failure to appoint counsel, all of which have served to conceal the competing interests involved.[14] Alexander and Lewin[15] have argued that:

> This kind of intervention is a basic deprivation of a right of an individual to self-determination. It is important to recognize that however benevolent the intention of those who would seek to substitute other decision-makers for the aged, persons deprived of the right to decide for themselves will have lost the fairly basic attribute of citizenship . . .

Both the examiners and the court should be alert to the possibility that the level of impairment is not great and that the patient might be more harmed by the adjudication of incompetency than by being permitted to manage business affairs which are of questionably poor judgment.[16]

The traditional standard of proof in competency proceedings is that of clear and convincing evidence. Considering the subjective and elusive nature of mental incapacity, proponents of a higher standard, namely, proof beyond a reasonable doubt, point to the stigma of incompetency and the accompanying loss of civil rights.[17] Hearsay evidence is introduced when a doctor's written opinion is the only testimony presented on the question of the individual's competency. If courts excluded hearsay evidence from competency hearings and required the examining physician's presence in court, the quality of medical testimony would become more reliable, benefiting both the petitioner and the proposed ward.[18]

The competency enigma •

> Between the idea and the reality
> Between the motion and the act
> Falls the shadow.
>
> T. S. Elliot
> The Hollow Men

There has evolved an inverse relationship between the sophistication of diagnosis and treatment and its influence on the determination of legal competency. Combined with cost factors and crowded court dockets, the effects may be observed in cursory examinations resulting in imprecise, repetitive diagnoses communicated to judges on standardized forms. One marvels at such simplistic approaches to issues which are complex, highly subjective, and individualized with consequences for the patient of sweeping proportions.

The National Institute on Aging recommends that examination of a mentally impaired elderly patient include a detailed history, comprehensive physical examination, complete review of all medications, mental status and psychiatric evaluation, and ancillary examinations as indicated. Further, it is pointed out that in 10% to 20% of patients with intellectual impairments these conditions are reversible.[19] A later study of nursing home residents found that 26 out of 136 (19%) having a diagnosis of senile dementia actually had treatable problems.[20] Commonly identified causes of reversible dementia include therapeutic drug intoxication, depression, and

metabolic or infectious disorders. A thorough physical examination is vital because disease in any organ system may cause dementia or delirium.[21]

Depression in the elderly may be accompanied by a mild to profound reversible dementia. Severe cases of this pseudodementia may make it very difficult to distinguish depression from Alzheimer's disease and misdiagnosis is not uncommon in settings where extensive multidisciplinary assessment is not available.[22] Kahn and Miller[23] describe the serious consequences for the patient of an incorrect diagnosis of irreversible dementia. It can generate a sense of hopelessness about the patient so that treatable causes may not be evaluated. Under such circumstances family, friends, service providers, and even patients themselves will give up on possibilities of change. Translated to a guardianship with the finality of a judicial ruling, the ramifications become frighteningly clear.

Competency is a functional concept rather than a diagnosable condition. While founded in law and subject to judicial determination, the reality is quite different. The psychiatrist is often called upon to decide if a judicial determination of incompetency is justified, and once the case arrives in court the psychiatrist's assessment often serves as the only source of information to guide the judge's decision.[24] Indictments against the diagnostic examination traditionally accepted in competency hearings focus on the fact that neither the presence of mental illness nor the fact that a patient has been committed is adequate reason to warrant a presumption of incompetency. It has been shown, however, that examining committees recommend guardianship with very few exceptions.[25] The current trend is toward assessing an individual's competency to perform specific functions — the diagnosable condition being relevant only to the extent that it influences specific capacities.[26]

Mildly demented patients, for example, might function quite well in the familiar environment of their home but show marked confusion and disorientation after admission to the hospital.[27] Some elderly people have quite successfully constructed useful social supports for themselves to compensate for insidiously developing incapacities. The filing of competency petitions should be uncommon in the hospital setting due to the artificial environment and circumstances in which the patient is being observed and assessed. Clearly, an incompetent state may be a symptom of illness and, like any other symptom, can respond to the indicated treatment.[28] While the need for cautious assessment should be evident, clinicians who would refuse to propose a psychiatric diagnosis for an outpatient after one visit are often surprisingly willing to declare a patient competent or incompetent on the basis of a single brief interaction.[29]

A sufficient evaluation of competency for judicial proceedings necessitates a functional assessment. A clinical competency evaluation is performed in order to design an intervention strategy to meet the patient's needs. Functional status is more than a diagnosis and promotes a more holistic approach to identifying strengths and weaknesses in a variety of areas and to understanding how the person is functioning overall. The Functional Assessment Inventory (FAI) and the Geriatric Assessment Testing and Evaluation System (GATES) developed at the Suncoast Gerontology Center offer practical approaches to the dilemma.[30] These tools evaluate the patient's current status in the areas of physical health, mental health, social and economic resources, and the capacity for self care. The advantages of a multidimensional approach to competency examinations are these: the court will be provided with a more comprehensive understanding of the alleged incompetent and his needs; the proposed ward will benefit from having a more accurate and complete evaluation by which the court can decide on the need for guardianship, its most intrusive option; and, if adjudication is ordered, both family and professional guardians will benefit from the development of a multidisciplinary service prescription to guide their work with the ward.

Conclusion • Participants in the guardianship process and concerned observers tend to be traditionalist supporters or prophetic reformers. Yet, efforts to modernize the guardianship laws have met with dismal failure largely due to apathy on the part of influential members of the organized bar and the judiciary. While many attorneys, social workers, clinicians, and advocates believe that responsible revision would be beneficial, consensus has not been achieved. It is probable that a significant number of cases that end in guardianship could be managed in less costly ways with less ominous social and legal consequences for the individual. Before a petition to determine competency is filed, these suggested minimum criteria should be met: (1) The presence of physical and/or mental incompetence has been established; (2) Practical alternatives have been explored; (3) Clear objectives have been identified; (4) There exists the likelihood of benefit for the proposed ward; (5) There is a suitable guardian available.

In the medical care setting, determinations of incapacity are best handled without routine recourse to the courts. Pursuing judicial proceedings to confirm the patient's lack of decisional capacity is often so costly and burdensome to providers and patients or their families that there is great reluctance to do so. Even when an adjudication of incompetency is sought, the proceedings are so routine and deferential to medical opinion that the role of the court amounts to little more than a formal ratification of what was already apparent to health professionals.

Whenever possible, surrogate decision making should be confined to the patient-doctor-family relationship. Every possible attempt must be made to replicate decisions which the patient would have made when competent, using a substituted judgment standard.[31]

The long-term management of impaired people is complicated by persisting stereotypes about the elderly, retarded, and mentally ill. These may influence other's perceptions of their capabilities, limitations, and how to effectively meet their needs. Human service professionals are in a leadership position to ensure that solutions to human problems are the least intrusive and restrictive available.

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Anxiety, depression and health locus of control orientation in an out-patient elderly population

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ABSTRACT: Disease states, one's living situation, and one's beliefs about health locus of control may put the elderly at risk for suffering from depression and anxiety.

The results of the Zung Self-Rating Depression Scale, the short form of the Taylor Manifest Anxiety Scale, and the Health Locus of Control Orientation Scale (HLC), which has been administered to 22 ambulatory elderly patients were correlated with disease states and social factors.

Sixty-eight percent of the patients rated clinically anxious. Eighty-four percent had an external helath locus of control and 15.6% an internal locus. The mean HLC score for all was strongly external. One hypothesis was that the normal uncontrollable process of aging results in a sense of a lack of control over health.

The aging process may result in feelings of externality and mimic symptoms of depression and anxiety. Activities and relationships with others, rather than number of chronic diseases, may more strongly influence the degree of depression and anxiety experienced by the elderly person.

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Persons with anxiety, depression, or other psychological difficulties usually seek help from primary care providers.[1] They complain of various symptoms which may direct the primary care provider away from emotional difficulties as the underlying cause.

Symptoms of anxiety, depression, or both commonly accompany physical disease. In a large survey Hankin et al[2] found that patients with a diagnosis of a mental disorder were more likely than those without a mental disorder to receive diagnoses involving neoplasms, endocrine, nutritional and metabolic diseases, and the diseases of the circulatory, digestive, and genitourinary systems. The most statistically significant difference between the two groups was found in the "signs, symptoms, and ill-defined conditions" category, which occurred one and one-half times more often in persons with a mental disorder than without a mental disorder.

Depression is common among elderly persons.[3] Anxiety alone or with depression is commonly seen in medical patients. Symptoms of anxiety are also more prevalent among elderly persons than in other age groups. Chronic anxiety is found in 10 percent of the elderly while nearly 20 percent take prescribed antianxiety drugs.[4] Anxiety is frequently expressed through somatic, cognitive, or both types of symptoms.

Recently Molinari and Khanna[5] have focused on Internal-External Health Locus of Control orientation and its relationship to health behaviors. An Internal Health Locus of Control orientation suggests that the individual believes his health is directly related to his behavior and thus he can exercise some control over his health. The individual with an External Health Locus of Control orientation believes

his health is related to fate, luck, chance, and external circumstances beyond his control. Patients with an internal orientation are more likely than those with an external orientation to change health damaging behaviors and to take steps necessary to alter adverse life situations. Those with an internal orientation also respond better to patient teaching which can affect compliance and health maintenance behavior.[6]

Health maintenance is important for the elderly who need to follow the medication, dietary, and exercise regimens for such common problems as hypertension, heart disease, and arthritis.[6] Few studies of the effects of Health Locus of Control among elderly patients have been published. In addition, the relationship between Health Locus of Control and depression or anxiety has not been extensively studied. Studies of younger persons have found that depression is associated with an external locus of control.[7] Molinari and Khanna[5] suggest that internal orientation is linked to less debilitating anxiety than external orientation.

Our study was undertaken first to determine the frequency of depression and anxiety symptoms among a sample of geriatric outpatients. A second issue was the degree to which social contacts, activities, and disease states affected the degree of felt depressive or anxiety complaints among elderly outpatients. A third issue was the relationship between Health Locus of Control Orientation and the presence of depression and anxiety.

Method — Subjects • Twenty-two consecutive patients seen in a geriatric outpatient clinic who agreed to participate in the study, constituted the sample. All subjects were residents of a HUD apartment complex which physically housed the clinic. The five men and 17 women in the sample reflected the patient sex ratio of the clinic. Four men and two women were married. The remaining were single or widowed. The mean age of the sample was 76.0 years.

Procedure • Patients were recruited by the clinic secretary or the nurse practitioner on either their initial visit to the clinic or, more typically, on a follow-up visit. The secretary assisted the patients in completing the questionnaires by reading the items to them and recording answers. The questionnaires were scored by members of the research team. Subsequent to collecting the questionnaire data, the medical records of each participant were reviewed for the following information: age, sex, marital status, number in household; primary and secondary diagnoses; clinical notations of the presence of anxiety and depression; prescriptions for antidepressants or antianxiety medications; notations regarding difficulties in complying with medical treatment; daily activities; availability of family support; and social involvement.

Questionnaires Employed: Each patient was given the following three short self-report questionnaires.

1. Zung-Self-Rating Depression Scale (SDS):[8] A 20-item questionnaire used to evaluate the presence of physical or psychological symptoms associated with depression. Each item on the scale (e.g., "I feel downhearted and blue") is endorsed by the patient in one of four categories: a little bit, some of the time, a good part of the time, most of the time. Items were assigned a score of 1-4, with a score of 4 being most indicative of depression. These scores were totalled to obtain a raw score (range of possible values 20-80). The SDS index score was calculated by dividing the total raw score value by 80, which was converted to a decimal and multiplied by 100 (range of possible values 25-100). An SDS index score of 50 or greater was rated significant for clinical signs of a depressive disorder.

2. Taylor Manifest Anxiety scale (TMA):[9] The brief form of this scale consists of 20 statements selected from the Minnesota Multiphasic Personality Inventory.[10] Each statement (e.g. "I believe I am no more nervous than most people") can be endorsed by the patient as either true or false. Scale content reflects symptoms of physiological or psychological changes associated with anxiety. The TMA score was obtained by assigning one point for each endorsed item which was indicative of anxiety. The total of these was taken (range of possible values 0-20). Scores of 10 or more were judged to be clinically significant for the presence of anxiety symptoms.

3. Health Locus of Control Scale (HCL):[11] This 11-item scale assesses the degree to which a patient perceives personal influence on health and health care behaviors. The scale was scored so that each item (e.g. "If I take care of myself, I can avoid illness") was endorsed on a five-point Likert type scale from strongly disagree to strongly agree. One to six points were assigned to each response, with the higher values given to those responses most indicative of an external health locus of control. Possible scores ranged from 11 to 66 with the published cutoff for classification as having an external locus of control orientation equal to scores of 35 or more.

Results — Self-report of depression • The mean Zung score for the entire sample was 54.6, which was above the cutoff score of 50 or more for clinical depression. Fifteen of the 22 patients (68.2%) self-rated themselves clinically depressed (mean Zung score = 58.3).

Only three of these 15 (20%) were also diagnosed as depressed by the clinic medical staff. The mean Zung score of these three patients was 56.2. The

clinical diagnosis of depression was made in two patients who did not self-rate depressed (mean Zung score = 36.5).

The mean rating for each item was examined with the range of scores being between one and four; the higher the score, the more indicative of depression (Table 1). The highest scores occurred on those items which involved sexual satisfaction, changes in one's ability to carry on life activities, appetite, enjoyment of activities, feelings of worth and hopefulness about the future. In contrast, the lowest scores were found on items which reflected feelings about wanting to die, emotional symptoms such as crying spells, weight loss, palpitations and mood changes, sleep disturbance and restlessness.

The mean score of all items reflecting the cognitive signs of depression was 2.1 (items #1, 8, 11, 14, 15, 16, 17, 18, 19, 20). The mean score of all items reflecting the somatic signs of depression was 2.3 (items #2, 4, 5, 6, 7, 8, 9, 10, 12, 13).

Self-report of anxiety • The mean TMA score for the entire sample was 7.00, which is below the cutoff score of 10 or more for the diagnosis of anxiety. Five of 22 patients (22.7%) self-rated themselves as clinically anxious. Their mean TMA score was 12.6. All patients who self-rated anxious also self-rated depressed.

Of the five patients who self-rated as anxious, only one, with a TMA score of 11, was clinically diagnosed as anxious by the medical staff. In contrast, six patients who did not self-rate as anxious were labelled anxious by medical personnel (mean TMA = 5.5). There were six patients being treated with anxiolytic agents, none of whom self-rated as anxious (mean TMA = 5.7).

The Taylor Manifest Anxiety scale was then subjected to analysis of items (Table 2). The TMA items seemed heavily weighted toward feelings about and cognitive symptoms of anxiety rather than physical complaints such as tremor, sweating or restlessness.

Since all patients with elevated TMA scores also had elevated Zung scores, the Zung scale was reexamined for items which could indicate anxiety symptoms. Cognitive symptoms of anxiety are measured by items 3, 15, 12, 20, 17, and 11 and somatic symptoms by items 10, 13, 9, 4, 5, and 7. Those who self-rated anxious had a mean score of 2.3 on the cognitive items and a mean score of 2.4 on the somatic items, suggesting that anxiety symptoms were not a component of their elevated depression score.

Health locus of control orientation • The mean HLC score for the entire sample was 39.4 which is above the external orientation cutoff score of 35. Nineteen patients (84.4%) rated themselves as having an external health locus of control orientation (mean score = 40.3%). One patient was eliminated because of missing or duplicate responses on her HLC testing. The association between HLC orientation compliance with one's medical regimen was examined. Of those tested, 15 were judged to be compliant with their medical regimens, and six were noncompliant. Of the two persons with an internal HLC orientation, one was compliant and one was not compliant with their medical regimens.

An item analysis of the content of the Health Locus of Control Scale was conducted. The range of possible scores on each item was one to six, with six being the most external HLC, and one being the most internal HLC. Table 3 presents the mean scores per item. As can be seen, the highest mean scores were obtained on items which reflected the belief in the inevitability of illness and on the role of fate in sickness. The lowest mean score was found on the item which reflected feeling direct responsibility for one's health.

Disease states • Medical records review showed an average of five chronic diseases per patient with an average of 0.3 life threatening diseases per patient, and 0.9 acute diseases per patient. No person had less than three diseases. Table 4 presents the mean number of disease states in the patient sample according to their ratings on the Zung SDS, TMA and HLC measures.

Among the patient sample, 36.3% of persons had impaired mobility which necessitated the use of a cane, walker, or wheelchair or which limited their ability to walk one city block without pain (angina, arthritis), shortness of breath, or dizziness. Of these persons, 87.5% self-rated depressed, 50% self-rated anxious, and 50% were both anxious and depressed.

The medical data were then examined according to type of disease (including ill-defined conditions) and the presence of anxiety or depression or both. There were no significant differences in the number of patients with and without anxiety or depressive symptoms across all disease types, including ill-defined conditions, except for neoplasms in which more patients were found to have depressive disorders.

Social situations and supports • Of the total sample, 68.2% of persons lived alone. Sixty percent of these were depressed and 6.7% were anxious. All of those who were anxious were also depressed. Of the 31.8% of persons living with someone, 85.0% were depressed and 57.1% were anxious.

The majority of patients (72.7%) were identified as having family supports. Of these, 62.5% were depressed, and 31.2% were anxious. Anxiety and depression were found in 31.2% of these persons. Those 18.2% with no family support all were depressed and none were anxious. Two persons were

Table 1. — Zung SDS — Mean Scores per Question (range 1-4)

Item Number		All N = 22	Anxious N = 5	Depressed N = 15	Non-anxious Non-depressed N = 7
6	I still enjoy sex.	3.9	4.0	3.9	1.9
*12	I find it easy to do the things I used to do.	3.1	3.4	3.2	3.0
** 5	I eat as much as I used to.	3.0	2.8	3.1	2.9
*20	I still enjoy the things I used to.	2.9	3.0	3.2	2.1
*17	I feel that I am useful and needed.	2.8	1.8	2.8	2.7
18	My life is pretty full.	2.7	2.0	3.1	1.9
14	I feel hopeful about the future.	2.7	2.8	3.0	2.1
2	Morning is when I feel best.	2.6	1.6	2.9	1.9
16	I find it easy to make decisions.	2.4	2.0	2.6	2.1
*11	My mind is as clear as it used to be.	2.4	2.0	2.5	2.1
**10	I get tired for no reason.	2.1	3.0	2.1	2.1
8	I have trouble with constipation.	2.0	2.8	2.1	1.7
**13	I am restless and can't keep still.	1.7	2.2	1.8	1.6
** 4	I have trouble sleeping at night.	1.6	2.2	1.7	1.4
1	I feel downhearted and blue.	1.6	2.6	1.8	1.0
** 9	My heart beats faster than usual.	1.5	2.4	1.6	1.3
** 7	I notice that I am losing weight.	1.4	1.8	1.6	1.4
*15	I am more irritable than usual.	1.4	1.8	1.3	1.4
* 3	I have crying spells or feel like it.	1.3	2.0	1.4	1.0
19	I feel that others would be better off if I were dead.	1.5	1.6	1.3	1.0

* = cognitive symptoms of anxiety
** = somatic symptoms of anxiety

Table 2. — Taylor Manifest Anxiety Scale — Percentages of Responses Indicative of Anxiety Per Scale Item

Scale Item	Response Indicative of Anxiety	All N = 22	Anxious N = 5	Depressed N = 15	Non-anxious Non-depressed N = 7
I certainly feel useless at times	(T)	54.4	60.0	53.3	57.1
At times I feel no good at all	(T)	50.0	100.0	66.7	14.3
I frequently find myself worrying about something	(T)	45.4	100.0	53.3	28.6
I am more sensitive than most other people	(T)	45.4	80.0	53.5	28.6
I have sometimes felt that difficulties were piling up so high that I could not overcome them	(T)	45.4	100.0	53.3	28.6
I have periods of such great restlessness that I cannot sit long in a chair	(T)	40.9	80.0	53.3	28.6
I believe I am no more nervous than most people	(F)	40.9	40.0	40.0	42.9
I am not usually self-conscious	(F)	40.9	40.0	33.3	57.1
I sometimes feel that I am about to go to pieces	(T)	40.9	80.0	53.3	14.3
I feel anxiety about someone or something almost all the time	(T)	36.4	80.0	33.3	42.9
I am a high strung person	(T)	36.4	80.0	46.7	14.7
I shrink from facing a crisis or difficulty	(T)	36.4	80.0	40.0	28.6
I am inclined to take things hard	(T)	31.8	60.0	46.7	-0-
I am certainly lacking in self-confidence	(T)	31.8	60.0	40.0	14.3
I find it hard to keep my mind on a task or a job	(T)	31.8	60.0	40.0	14.3
I am happy most of the time	(F)	27.3	-0-	26.7	28.6
I work under a great deal of tension	(T)	27.3	60.0	33.3	14.3
Life is a strain for me most of the time	(T)	27.3	40.0	40.0	-0-
I cannot keep my mind on one thing	(T)	27.3	40.0	26.7	14.3
I am usually calm and not easily upset	(F)	22.7	20.0	26.7	14.3

not included in this analysis because it was not known if they had family supports.

Fifty percent of persons described community interests, activities with friends, and hobbies. Of these, 54.4% were depressed and none were anxious. Of the 50% of persons who had no particular interests, social activities, or hobbies, 72.7% were depressed and 45.4% were anxious. All of those who were anxious were also depressed.

Three patients were known to have "no money" for medications, and all of these patients were depressed, and 66.7% were both anxious and depressed.

Discussion and conclusions — Depression in the elderly outpatient • In the sample of elderly outpatients, 68.2% self-rated as depressed, yet only

20% were diagnosed by the attending clinical medical staff as depressed. Two persons were diagnosed as depressed who, in fact, did not self-rate depressed. While there is controversy as to the appropriateness of the Zung scale in assessing depression in elderly patients,[12] the present findings suggest that depression is frequently missed among elderly ambulatory patients. Elderly depressives are at significant risk for suicide with between 5,000 and 8,000 a year completing the act which makes the detection of depression important in this population.[13]

Zung[3] found that depressed elderly persons commonly endorsed symptoms related to personal devaluation, emptiness, indecisiveness, dissatisfaction, hopelessness, psychomotor retardation, suicidal rumination and confusion and concluded that the major causes of depression in the aged are related to apathy, disinterest, feelings of inferiority, and loss of self-esteem. Similar to Zung's findings, our patients frequently indicated problems regarding decreased libido, psychomotor retardation, dissatisfaction, and personal devaluation, all common complaints in depression. Considering the sexual mores of this sample's generation and the decreased ratio of men to women, one might suspect that the majority of our patients who were unmarried (72.7%) do not engage in sexual activity and thus would respond highly negatively to the statement, "I still enjoy sex." Several persons laughed or became indignant about this question. One woman became hostile and said, "I'm not crazy. What kind of questions to ask a 75-year-old!"

Table 3. — Mean Scores Per Item, Health Locus of Control Scale. In Descending Order from Most Indicative of External Health Locus of Control towards Those Most Indicative of Internal Health Locus of Control (Range 1-6)

Item Number	Item	All	Anxious N = 5	Depressed N = 15	Non-anxious Non-depressed N = 7
4	No matter what I do, if I am going to get sick, I will get sick	4.0	5.2	4.5	3.7
9	People who never get sick are just plain lucky	4.0	5.5	4.2	3.0
7	There are so many strange diseases about that you can never know how or when you might pick one up	3.9	4.5	3.9	3.8
5	Most people do not realize the extent to which their illnesses are controlled by accidental happenings	3.8	4.2	3.9	4.1
2	Whenever I get sick it is because of something that I have done or not done	3.5	3.4	3.7	3.3
6	I can only do what my doctor tells me to do	3.4	3.6	3.6	3.0
10	People's ill health results from their own carelessness	3.4	3.2	3.3	3.8
3	Good health is largely a matter of good fortune	3.4	4.4	3.7	3.4
8	When I feel ill, I know it is because I have not been getting the proper exercise or eating right	3.1	2.8	3.4	3.1
1	If I take care of myself, I can avoid illness	3.0	2.8	2.9	3.1
11	I am directly responsible for my health	2.7	2.2	2.7	3.1

Table 4. — Disease States in Relationship to Anxiety, Depression, and Health Locus of Control

Mean numbers of:	Chronic diseases	Life-threatening	Acute
Depressed (15)	4.7	0.3	1.1
Non-depressed (7)	5.7	-0-	.43
Anxious (5)	4.8	-0-	1.2
Non-anxious (17)	5.1	0.3	0.8
Externals (19)	5.1	0.3	0.9
Internals (2)	5.0	-0-	0.5

Declining physical abilities may have accounted for the high scores on the questions pertaining to the ease of doing things, the pleasure obtained by doing things "I used to do," and the feelings of being useful and needed. The changes in physical functioning which can accompany aging and physical illness may mean that the elderly person can no longer participate in certain activities or that an activity may have become difficult to do because of physical limitations. If one is unable to do the things one used to do, one's feelings of being useful and needed will surely be affected. Blazer[14] noted that 44% of the persons with depressive symptoms had physical health impairment and it was thought that grief, secondary to loss of good health functioning, physical discomfort, pain, and consequences of loss of the capacity to take care of oneself may all contribute to these symptoms. He then suggested that much of what is called "depression" in the elderly may actually represent decreased life satisfaction and periodic episodes of grief secondary to the physical, social, and economic difficulties encountered by aging individuals in the community.[14]

Our patients did not typically complain of other manifestations of depression such as suicidal thoughts, crying spells, increased irritability, palpitations, and feeling downhearted and blue. The Zung scale may not accurately measure depression in the elderly because some of the limitations and changes of old age may cause one to respond in a manner indicative of depression. The self-report of psychomotor symptoms (agitation or retardation) and pervasive affective disturbances (feelings of sadness, tearfulness) were low. However, the clinical diagnosis of depression most frequently was given to patients reporting difficulty falling asleep, irritability and crying spells or feelings of sadness. One elderly patient in our sample often denied depressive symptoms during the medical interview, suggesting that a self-report measure may alert the primary care provider to pursue the possibility that somatic complaints may be masking an underlying depressive disorder.

While a self-report instrument such as the Zung self-rating depression scale can be a useful tool in the assessment of depression in the older person, it alone is probably not an accurate measure of depression in the older person. It is important not to take each item at face value, but to examine each item in relation to the person's physical condition, limitations, life style, living situations, and attitudes.

Anxiety • Although almost a quarter of our sample rated themselves clinically anxious, only one patient was diagnosed as clinically anxious by the medical staff. Furthermore, none of the patients on anxiolytic medications self-rated as anxious. This may indicate that the medication was working or that these patients were not anxious initially. Surprisingly, six patients who did not self-rate anxious were clinically diagnosed as anxious. Examination of the cognitive versus somatic symptoms of anxiety as reflected in the TMA scale and the Zung scale indicated that somatic symptoms of anxiety were more frequently noted than cognitive symptoms. These results are consistent with those of Gurin et al[15] suggesting that somatic components of anxiety are more common in the older age groups. Similar findings were obtained for the TMA scale and the Zung in that many patients endorsed items pertaining to feelings of uselessness or feeling no good at all. Both of these responses may be related to the elderly patient's decreasing ability to do the things they used to do and their feelings of uselessness surrounding this loss rather than to pervasive anxiety disorder. Indeed, almost half of the sample indicated that they often find themselves worrying about something and feel overwhelmed by their life's difficulties. These findings suggest that although the aged feel overwhelmed at times, these feelings may be a realistic response to their problems in living since few of our patients also reported that they lacked self-confidence and the majority claimed they were happy most of the time.

In general, our clinic sample manages fairly well in an independent life style in spite of the changes aging brings — illness, and limited income. Clinically there appeared to be little debilitating anxiety which is characterized by obsessive worry and fear to the extent of hindering one's ability to function.[16] It could be that facilitative anxiety, the anxiety which causes one to feel eagerness or motivation,[16] may be identified as "anxiety" in the clinic by the attending physicians and that this is not being measured on the TMA.

Surprisingly, higher anxiety scores were obtained by those patients who were living with others than by those who lived alone. One could speculate that social contact permitted more exchange of anxious concerns about diminished health and economic resources or, that since 86% of those living with someone were married, that changes within the marital relationship or within one's spouse resulted in feelings of anxiety and depression. Furthermore, there was more depression as well as anxiety in those who did not describe community interests, activities with friends, or hobbies. This lack of directed activity probably results in increased feelings of uselessness and loss of self-esteem. It also allows time to concentrate on one's own situation, to mourn losses, and to think about the future.

Health locus of control • The majority of our subjects scored in the external orientation range. Those items scoring highest were those that pertained to chance occurrences or inevitability of getting sick. At the same time, persons scored lowest (internal orientation) on the item, "I am directly responsible for my health." On the surface, these results would appear to contradict each other; however, it may be that most were concerned about their health and the majority complied with their medical regimens despite their belief that illness was an inevitable consequence of aging. Whether the external orientation toward health care in our sample is representative of the elderly population in general remains to be determined. The relationship between health locus of control orientation and the presence of depression and anxiety could not be determined due to the small number of externals in the study. Additional studies, employing larger samples of persons are needed to determine if people develop an external health locus of control as they age and to provide more insight into the relationship between their health care attitude compliance with their health.

Summary • The diagnosis of anxiety or depression in the elderly is a common problem which should be considered when a variety of physical and cognitive complaints are encountered by the primary care provider. Careful questioning and examination can elicit a number of diagnostic symptoms. The Zung SDS and the TMA scale may be used as adjunct tools in making the diagnosis but it must be remembered that items on these scales may be more indicative of changes that have occurred with aging or chronic illness which may or may not have been adjusted to, and are not necessarily indicative of severe depression or anxiety.

Increasing social contacts, activities, and hobbies may result in a decreased incidence of depression and anxiety. These should be encouraged in our elderly population.

The Health Locus of Control scores tended strongly towards the external. The uncontrollable process of aging which brings with it decline in bodily functions and an increased incidence of chronic disease, may induce feelings of externality in the elderly. The current study suggests that there is a relationship between the severity and acuteness of physical disease and the experience of control over one's health.

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- Contains up-to-date information on the clinical use of drugs
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- Can identify drugs according to indications for therapy, special patient circumstances, or for certain drug actions and interactions

Excerpta Medica Physicians Information Retrieval and Educational Service

- Index to clinical literature — aids subscribers in locating recent articles and peer reviewed papers that have appeared in more than 300 medical journals worldwide
- Periodicals selected for inclusion in this service cover over 78 specialties and subspecialties
- Helps physicians locate relevant articles quickly and to stay abreast of new developments — saves time

Continuing Medical Education

- Developed by Massachusetts General Hospital in conjunction with the Harvard Medical School
- Allows physicians to earn Category I ACCME credits
- Provides individualized self-paced learning experiences based upon computer simulated patient cases
- Physicians will interact with teaching situation through four predetermined styles: multiple choice, vocabulary, fee text, and tutorial
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- Guide for locating current articles on the nonclinical aspect of health care
- Includes 4,200 citations from more than 700 health care publications
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- Convenient ordering of full text reprint of articles directly from the AMA through MED/MAIL

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- Provides uniform coding and nomenclature system for reporting medical services and procedures performed by physicians
- Contains 6,000 descriptions of procedures

Disease Information

- Contains descriptions of diseases, disorders and conditions

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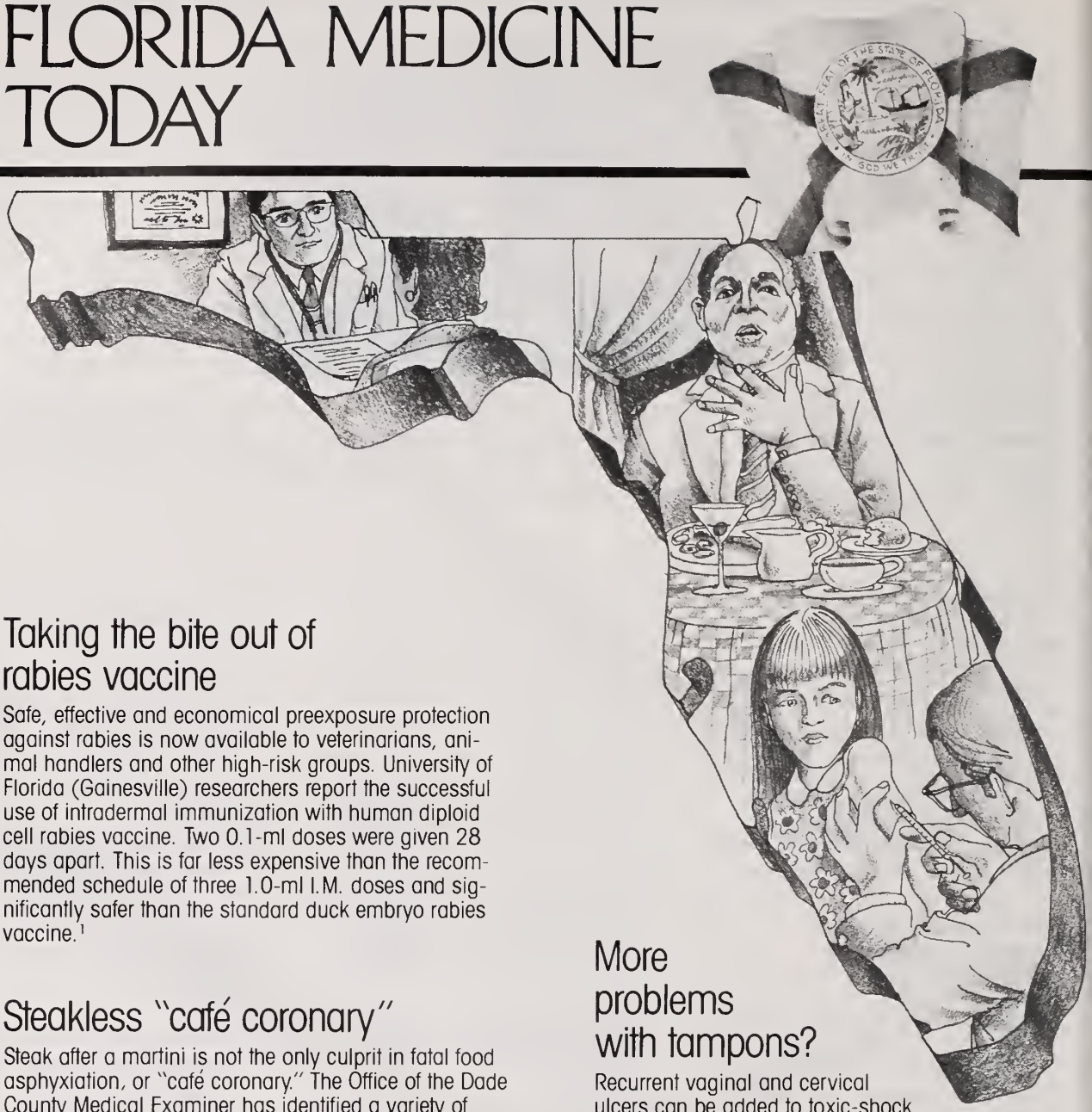
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FLORIDA MEDICINE TODAY



Taking the bite out of rabies vaccine

Safe, effective and economical preexposure protection against rabies is now available to veterinarians, animal handlers and other high-risk groups. University of Florida (Gainesville) researchers report the successful use of intradermal immunization with human diploid cell rabies vaccine. Two 0.1-ml doses were given 28 days apart. This is far less expensive than the recommended schedule of three 1.0-ml I.M. doses and significantly safer than the standard duck embryo rabies vaccine.[1]

Steakless "café coronary"

Steak after a martini is not the only culprit in fatal food asphyxiation, or "café coronary." The Office of the Dade County Medical Examiner has identified a variety of predisposing factors: medical institutionalization, sedative drugs, parkinsonism, old age, poor dentition and alcohol consumption. With institutionalized adults, friable foods not amenable to the usual rescue techniques are often involved. Observers were present in a full 85% of fatal cases, indicating a need for increased public awareness. Instruments for retraction of foreign bodies should be made readily available at public facilites and nursing homes. And new techniques should be developed to deal with soft foods that cannot be cleared by a grasping device or the Heimlich maneuver.[2]

More problems with tampons?

Recurrent vaginal and cervical ulcers can be added to toxic-shock syndrome as tampon-associated ailments. A report from South Miami Hospital indicates they may occur in one-fifth of menstruating women and are more common with long-term use. Moreover, microulceration has been reported within one hour after tampon insertion. Symptoms may also be subtle and often the same as those for which tampons are used, including spotting and discharge. Dyspareunia, urinary frequency and urgency and dysuria may also be present. Care must be taken to avoid undue delay in the diagnosis and to rule out carcinoma.[3]

References: 1. Burridge MJ *et al: JAMA 248* 1611-1614, Oct 1, 1982
2. Mittleman RE, Wetli CV: *JAMA 247* 1285-1288, Mar 5, 1982
3. Weissberg SM, Dodson MG: *JAMA 250*:1430-1431, Sep 16, 1983

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A rational approach, combining
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Convenient single *h.s.* dosing sufficient in some patients; helps patients with mixed depression and anxiety sleep through the night. Patients should be cautioned about the combined effects of Limbitrol with alcohol and other CNS depressants, and about activities requiring complete mental alertness such as operating machinery or driving a car.

In moderate depression and anxiety

IN PLACE OF LIMBITROL 5–12.5 WRITE: **Limbitrol®** Ⓘⓥ

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)

IN PLACE OF LIMBITROL 10–25 WRITE: **Limbitrol® DS** Ⓘⓥ

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt)

Easier to remember... easier to prescribe

*Feighner JP, *et al Psychopharmacology 61* 217-225, Mar 22, 1979

Please see summary of product information on following page.

LIMBITROL® Ⓥ Tranquilizer-Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety.
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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FMA Committee on Impaired Physicians

FLORIDA MEDICAL

DEPARTMENTS

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☐ NOTES & NEWS

JFMA featured in Medical Journalism

The Journal of the Florida Medical Association, Inc., was featured in the March 1985 issue of *Medical Journalism*, a publication of Sandoz Pharmaceuticals. The article reviewed the July 1984 Historical Issue of the *JFMA* edited since 1966 by William M. Straight, M.D. Dr. Straight's summary of the nineteenth Historical Issue was reprinted verbatim and the author observed that the articles ". . .seem to bring out the best writing and design skills of journal editors." In addition to its series of Historical Issues, the *JFMA* was commended for its many cover drawings by Andre Renard, M.D. depicting the lead article.

AMA PSAs promote positive aspects of aging

New public service announcements promoting the positive aspects of aging have been produced by the AMA. The announcements target the themes, "Share the experience of a lifetime" and "Just because you're 65, don't retire from life." The PSAs have been distributed to major television and radio stations and to medical societies interested in distributing the spots locally.

State and county auxiliary presidents have received a letter asking them to consider purchasing and distributing the announcements within their communities. The AMA Auxiliary will also provide posters and buttons free-of-charge to auxiliary members on request to promote the program.

Council on Hospital Medical Staffs holds its first statewide meeting

Thomas M. "Dan" Daniel, M.D., Chairman, Council on Hospital Medical Staffs announces the first annual statewide meeting of the Council on Wednesday, May 1, 1985 at the Diplomat Hotel, Hollywood, Florida. The meeting will be held from 8:00 a.m. until noon and all elected representatives from hospital medical staffs, county medical society hospital medical staffs chairmen, and county medical society executives are encouraged to attend. John M. McBryde, President, Florida Hospital Association, Inc. will be featured speaker. Among the major issues to be addressed are the following:

- Lack of medical staff voice in hospital governing board decision
- Effect of changes in hospital ownership on medical staffs
- Hospital cost containment
- Effect of PRO contracts with hospitals on industrial physicians and medical staffs
- Role of non-physician health care providers in the hospital
- Interpreting and complying with JCAH standards
- Closed medical staff arrangements and/or contractual arrangements

☐ 111th ANNUAL MEETING

Scientific program complete

The 111th Annual Meeting scientific program has been completed under the leadership of Pierre J. Bouis Jr., M.D., Chairman of the Council on Scientific Activities and Committee on Medical Education Chairman, Orris O. Rollie, M.D. Program highlights are listed below and as in the past, up to 20 hours of AMA Category I credit will be available to program registrants.

THEME SYMPOSIUM

"Quality Medicine in a Rapidly Changing Environment"
Thursday, May 3rd from 4:00 to 5:00 p.m.
Featuring:
Richard E. YaDeau, M.D.
Clinical Assistant Professor
Departments of Surgery and Family Practice
and Community Health
University of Minnesota

BIOETHICS AND THE PHYSICIAN

Thursday, May 3rd from 1:30 to 4:00 p.m.
Featuring:
David H. Smith, Ph.D.
Professor and Chairman
Communications and Comprehcnsive Medicine
University of South Florida College of Medicine
and
William T. Reich, S.T.D.
Professor of Bioethics
Georgetown University School of Medicine
Senior Research Scholar
The Kennedy Institute of Ethics

THE BASICS OF SEARCHING MEDLINE

Friday, Mat 4th from 7:30 to 10:45 a.m. and 1:30 to 5:30 p.m.
(Completion of this workshop fulfills the National Library of Medicine educational requirements for application to obtain a Mcdline user code. A $17 fee is required to cover the cost of educational materials and advanced registration should be mailed to: Robert C. Fore, Ed.D., Florida Medical Association, P.O. Box 2411, Jacksonville, Florida 32203).

SECTION ON ALLERGY AND IMMUNOLOGY

(Co-sponsored by Florida Allergy and Immunology Society)
Saturday, May 4, 1985—8:15 a.m. to 12:30 p.m.
Roger W. Fox, M.D., Tampa
Program Chairman

Welcome — Norman H. Wasserman, M.D., President, Florida Allergy and Immunology Society; Plantation

"AIDS — The USF Experience," Richard F. Lockey, M.D., Professor of Medicine and Pediatrics; Director, Division of Allergy and Immunology, University of South Florida College of Medicine, Tampa

"Calcium Antagonists in Asthma," Leslie Hendeles, Parm.D., Professor of Pharmacy and Pediatrics, University of Florida College of Pharmacy, Gainesville

"Adverse Reactions to Foods," John J. Stablein, M.D., Assistant Professor of Medicine, Division of Allergy and Immunology, University of South Florida College of Medicine, Tampa

"Non-IgE Mediated Drug Reactions," Raymond Slavin, M.D., Professor of Medicine and Microbiology, St. Louis University School of Medicine, St. Louis, Missouri

Coffee Break

"Immune Response Genes in Allergy," Mandel Sher, M.D., Clinical Assistant Professor of Pediatrics, University of South Florida College of Medicine, Tampa

"Immunologic Lung Diseases," Raymond Slavin, M.D., Professor of Mcdicine and Microbiology, St. Louis University School of Mcdicine, St. Louis, Missouri

Panel Discussion — Roger W. Fox, M.D., Moderator

Educational Objectives: The topics presented will inform the allergist and immunologist on the diagnosis and treatment of common clinical problems such as drug reactions, immunologic lung diseases, and certain reactions to food. Scientific reviews on calcium antagonists in asthma and immunogenetics will update clinicians in these very important, rapidly expanding areas.

SECTION ON CHEMICAL DEPENDENCY

(Co-sponsored by the Florida Medical Foundation Committee on Impaired Physicians and the Florida Chapter, American Medical Society on Alcoholism)
Thursday, May 2, 1985—1:00 p.m. to 4:00 p.m.
Arvey I. Rogers, M.D., Miami
E. Joan Barice, M.D., Palm Beach Gardens
Program Chairman

"Substance Abuse: Consequences and Implications"

Welcome — Guy T. Selander, M.D., Chairman, FMF Committee on Impaired Physicians, Jacksonville

Opening Remarks and Introductions — Arvey I. Rogers, M.D., Member, FMF Committee on Impaired Physicians, Miami

"Update Cocaine: A Continuing Craze of the '80's," Charles V. Wetli, M.D., Deputy Chief Medical Examiner, Dade County, and Associate Professor of Pathology, University of Miami School of Medicine, Miami

Questions and Answers

Break

"Medico—legal Implications of Physician Substance Abuse," Panel Discussion

Moderator—E. Joan Barice, M.D., President, Florida Chapter, American Society on Alcoholism, Palm Beach Gardens

Panelists—Richard J. Feinstein, M.D., Florida State Board of Medical Examiners, Miami; Dolores A. Morgan, M.D., Director of Addiction Services, Mount Sinai Medical Center, Miami Beach; Roger A. Goetz, M.D., Medical Director, FMF Impaired Physicians Program, Jacksonville; Deborah Miller, J.D., Practicing Attorney, Miami

Educational Objective: Two broad areas related to substance abuse will be considered. One will focus on a specific substance abuse, cocaine, which is widespread in our society. Audience participants can be expected to learn the status of the "cocaine craze" and hopefully, apply specific information concerning recognition, therapy and rehabilitation to their own practices and acquaintances. There are medico-legal implications of physician substance abuse which extend far beyond the recognition of physician impairment.

SECTION ON CHEST MEDICINE

(Co-sponsored by the Florida Chapter, American College of Chest Physicians and the Florida Thoracic Society)
Thursday, May 2, 1985—1:30 p.m. to 4:30 p.m.
Mark Snider, M.D., South Miami
Program Chairman

"AIDS 1985," Arthur Patchenik, M.D., Associate Professor of Medicine, Division of General Medicine and Pulmonary Medicine, University of Miami School of Medicine, Miami

Questions and Answers

"Laser Therapy of Bronchopulmonary Lesions," Alan L. Goldman, M.D., Professor and Director, Division of Pulmonary and Critical Care Medicine, University of South Florida College of Medicine, Tampa

Questions and Answers

"Asbestosis: Recent Scientific and Medical Legal Developments," Paul Epstein, M.D., Chief, Pulmonary Division, The Graduate Hospital, University of Pennsylvania Medical School, Philadelphia, Pennsylvania

Questions and Answers

Educational Objectives: To provide the physician with updated knowledge regarding AIDS, asbestosis, and pulmonary laser therapy. Recent developments, current impact, pulmonary implications and future trends will be reviewed.

SECTION ON COLON AND RECTAL SURGERY

(Co-sponsored by Florida Society of Colon and Rectal Surgeons)
Friday, May 3, 1985—1:30 p.m. to 5:30 p.m.
Emmett Ferguson Jr., M.D., Jacksonville
Program Chairman

"Golytely for Colon Cleaning," Major David Beck, U.S. Army Hospital, Patrick Air Force Base
"Technical Tips for Intermediate and Advanced Colonoscopy," John Christy, M.D., Miami
"Postoperataive Radiation Therapy Following Anterior Resection," Shed A. Roberson, M.D., Ormond Beach
"Operations of Choice for Cancer of Colon and Rectum," Emmett Ferguson Jr., M.D., Jacksonville
"Use of CO2 Laser in Low Lying Rectal Lesions," Harvey A. Shub, M.D., Orlando
Panel Discussion
Educational Objectives: The practitioner will be provided an update on current topics and procedures and will have an opportunity to participate in a panel discussion

SECTION ON DERMATOLOGY

(Co-sponsored by the Florida Society of Dermatology)
Friday, May 3, 1985—3:00 p.m. to 5:00 p.m.
Saturday, May 4, 1985—8:00 a.m. to 12:00 noon
Roger S. Golomb, M.D., Clearwater
Program Chairman

Friday, May 3, 1985
"Medicare Update for Dermatology," Richard C. Dever, M.D., Medical Director, Blue Cross/Blue Shield and Medicare, Jacksonville
"Peer Review: Its Frustrations and Values," Jerome Africk, M.D., Altamonte Springs
"Surgical Insurance and You," Panel Discussion — Jerome Africk, M.D., Altamonte Springs; Terence Cronin, M.D., Melbourne; Bernard Cohen, M.D., Miami; Charles Dugan, M.D., West Palm Beach
Saturday, May 4, 1985
Welcome — Roger S. Golomb, M.D., President
"Viruses and Genital Cancer — Wiley M. Sams Memorial Lectureship," Marvin Lutzner, M.D., Medical Director, National Institute of Health, Bethesda, Maryland
"Liver Toxicity with Etretinate Therapy for Psoriasis," David Sharaf, M.D., President, Department of Dermatology, Mount Sinai Medical Center, Miami Beach
"Transverse Sectioned Scalp Biopsy and Non Scarring Alopecia — Norman Fogel Memorial Lectureship," Alvin R. Solomon, M.D., Assistant Professor, Dermatology and Pathology, University of Texas Medical Branch, Galveston, Texas
Break
"Advances in Melanoma Pathology," Alexander P. Kowalczyk, M.D., Assistant Professor of Dermatology, University of Miami School of Medicine, Miami
"The Clinical Spectrum of Scleromyxedema," Nancy Simons Ling, M.D., Resident, Division of Dermatology, University of South Florida College of Medicine, Tampa
"Simple Surgical Suggestions for Special Situations — Ruth Dugan Memorial Lectureship," Jay Barnett, M.D., Clinical Associate Professor of Dermatology, New York Medical College, New York, New York
Educational Objective: To present and discuss several topics relating to the practice and management of dermatologic problems.

SECTION ON DIABETES

(Co-sponsored by the American Diabetes Association, Florida Affiliate)
Saturday, May 4, 1985—9:30 a.m. to 12:00 noon
Anthony D. Morrison, M.D., Tampa
Program Chairman

Welcome and Introduction — Ronald B. Goldberg, M.D., Assistant Professor of Medicine, University of Miami School of Medicine, Miami
"Definition, Classification, Diagnosis and Pathogenesis of Type II Diabetes Mellitus," Thomas G. Skillman, M.D., Professor Emeritus of Medicine, Ohio State University College of Medicine
"Management of Type II Diabetes Mellitus," Charles R. Shuman, M.D. Professor of Medicine, Temple University School of Medicine
Break
"Detection and Treatment of the Complication of Type II Diabetes Mellitus," Anthony D. Morrison, M.D., Associate Professor of Medicine, University of South Florida College of Medicine
Panel Discussion — Ronald B. Goldberg, M.D., Moderator
Educational Objectives: To communicate recent major advances in diabetes research and provide new information and management guidelines for the treatment of non-insulin dependent Type II diabetes mellitus; to provide consistence in the treatment of Type II diabetes mellitus that will result in optimal patient care as a result of diet, exercise and the selection of appropriate therapy to bring about and maintain control of this disease; and to provide primary care physicians with a written guide to the latest information on the treatment of Type II NIDDM for use in daily practice.

SECTION ON ENDOCRINOLOGY

(Co-sponsored by the Florida Endocrine Society)
Friday May 3, 1985—1:30 p.m. to 5:00 p.m.
Julio C. Pita Jr., M.D., Miami
Program Chairman

"Recent Advances in Clinical Thyroidology," Bruce Weintraub, M.D. Chief of the Molecular, Cellular and Nutritional Endocrinology Branch, National Institute of Arthritis, Diabetes, Digestive and Kidney Diseases in the National Institutes of Health
Questions and Answers
"Osteoporosis — Pathophysiology, Prevention and Treatment," Morris Notelovitz, M.D., Ph.D., Professor of Obstetrics and Gynecology, University of Florida School of Medicine, Gainesville
Questions and Answers
Break
"Thyrotropins and Gonadotropins, Clinical Implications," Bruce Weintraub, M.D.
Questions and Answers
Educational Objective: To receive basic principles in thyroid disorders with special emphasis on clinical application, and to review concepts in the evaluation and therapy of osteoporosis.

SECTION ON FAMILY MEDICINE

(Co-sponsored by Florida Academy of Family Physicians and Pfizer Pharmaceuticals)
Saturday, May 4, 1985—8:00 a.m. to 12:00 noon
William L. Stewart, Gainesville
Program Chairman

"Newer Drugs in the Management of Diabetes," Anthony D. Morrison, M.D., Division of Endocrinology, Veterans Administration Hospital, Tampa
"Malpractice Prevention — A Clinical Approach," Holger Rasmussen, M.D., Family Physician, Private Practice, Fremont, California
"Initial Work-up of the Patient with Arthritis," Norman B. Gaylis, M.D., Rhuematologist, Private Practice, North Miami Beach
"Better Patient Care Through Marketing," Andrew P. Morley Jr., M.D., Family Physician, Private Practice, Decatur, Georgia

Educational Objective: To provide the practicing physician with updated information on two important clinical topics in primary care and discuss some important medical economics topics (marketing and malpractice) that affect patient care and its delivery.

SECTION ON GASTROENTEROLOGY

(Co-sponsored by the Florida Gastroenterologic Society)
Friday, May 3, 1985—1:30 p.m. to 5:00 p.m.
Arvey I. Rogers, M.D., Miami
Program Chairman

"Digestive Disorders: Current Concepts"

Session I: Diagnosis

"The Hemoccult Positive Stool," John P. Christie, M.D., Member, Florida Gastroenterologic Society

"ERCP — Uses and Abuses," Jeffrey B. Raskin, M.D., Member, Florida Gastroenterologic Society

"Esophageal Manometry: When to Request and How to Interpret," Arvey I. Rogers, M.D., Member, Florida Gastroenterologic Society

"Hepatitis: Proper Use of Serologic Parameters," Rajevender Reddy, M.D., Member, Florida Gastroenterologic Society

Questions and Answers

Session II: Management

"Colon Polyps: Discovery and Remedy," John P. Christie, M.D.

"H-2 Receptor Blockers in Peptic Ulcers: Use and Abuse," Jeffrey B. Raskin, M.D.

"Inflammatory Bowel Disease: Pharmacotherapy Update," Arvey I. Rogers, M.D.

"Chronic Active Liver Disease," Rajevender Reddy, M.D.

Questions and Answers

Educational Objective: Update conflicts and controversies in important diagnostic and management aspects of common GI and liver problems.

SECTION ON NEUROLOGY

(Co-sponsored by Florida Society of Neurology)
Saturday, May 4, 1985—8:00 a.m. to 11:45 a.m.
Walter C. Martinez, M.D., West Palm Beach
Program Chairman

"Epilepsy: Current Art, Current Science"

"Overview and Introduction," Walter C. Martinez, M.D., Co-Director, Muscular Dystrophy Society of Palm Beach County, Palm Beach

"Diagnosis and Treatment Update," R. Eugene Ramsay, M.D., Associate Professor, University of Miami School of Medicine, Miami

"Prolonged Inpatient Monitoring," Michael Duchowny, M.D., Director, Seizure Unit, Variety Children's Hospital, Miami

Break

"Effects of Medications on Learning," Robert Cullen, M.D., Director of Child Neurology, Variety Children's Hospital, Miami

"Private Practice of Neurology: Past, Present, and Future," Willis N. Dickens, M.D., practicing neurologist, Ft. Lauderdale

Educational Objective: To review the present diagnostic tests and therapy relative to the practice of neurology.

SECTION ON NEUROSURGERY

(Co-sponsored by the Florida Neurosurgical Society)
Saturday, May 4, 1985—8:00 a.m. to 12:00 p.m.
Barth A. Green, M.D., Miami
Program Chairman

"Computerized Multichannel EMG Biofeedback," Bernard Brucker, Ph.D.,

"Computerized Closed Loop Functional Electrical Stimulation," Mark Nash, Ph.D.,

"Microlaser Neurovascular Reconstruction," Steve Hart, Director, Microsurgery Education

"Magnetic Resonance Imaging," Jerome Sheldon, M.D.

"CNS Regeneration," Barth A. Green, M.D., Associate Professor, Neurosurgery

Educational Objective: The course attendees will be familiar with the technology and application of computerized biofeedback, the technology and application of computerized functional electrical stimulation, gain an understanding of the use of the microlaser for the reconstruction of nerves and blood vessels, gain an understanding of magnetic resonance imaging (MRI) technology and its practical use in neurosurgery, and they will be presented with an overview of the state of the art laboratory research in CNS regeneration.

SECTION ON NUCLEAR MEDICINE

(Co-sponsored by Florida Association of Nuclear Physicians, Inc.)
Saturday, May 4, 1985—9:00 a.m. to 12:00 p.m.
Ronald D. Levy, M.D., Melbourne
Program Chairman

"The Potential of S.P.E.C.T," Frank DeLand, M.D., Head, Department of Nuclear Medicine, Princess Margaret Hospital, Ontario, Canada

"Lymphoscintigraphy in Breast Cancer," Gunes N. Ege, M.D., Head, Department of Nuclear Medicine, University of Kentucky Medical Center, Lexington

Break

"Lymphoscintigraphy in Other Cancers," Gunes N. Ege, M.D.

"Current Status of Radioimmuno Imaging," Frank Deland, M.D.

Educational Objective: To provide current information on topics related to the practice of nuclear medicine.

SECTION ON OBSTETRICS AND GYNECOLOGY

(Co-sponsored by the Florida Obstetric and Gynecologic Society)
Saturday, May 4, 1985—8:00 a.m. to 12:00 p.m.
Dale L. Taylor, M.D., Lakeland
Program Chairman

Introductions

(Selected scientific papers will be presented by residents and faculty from: University of Florida College of Medicine, University of South Florida College of Medicine, and University of Miami School of Medicine)

Educational Objective: A variety of topics will be presented on the practice of obstetrics and gynecology along with an opportunity for discussion.

SECTION ON OCCUPATIONAL MEDICINE

(Co-sponsored by Florida Occupational Medical Association)
Saturday, May 4, 1985—8:00 a.m. to 11:15 a.m.
Emmett B. Ferguson, M.D., Kennedy Space Center
Program Chairman

"Worker's Right to Know Legislation and the Physician," Nicholas Alexiou, M.D., M.P.H., President, Florida Occupational Medical Association; and Assistant Professor, Department of Comprehensive Medicine, University of South Florida, Tampa

"State-based Occupational Disease Surveillance Programs," - Robert Mullan, M.D., National Institute for Occupational Safety and Health, Surveillance Branch, Robert A. Taft Labs, Cincinnati, Ohio

"Registry of Occupational Illnesses," E. Lee Husting, Ph.D., M.P.H., Professor, Comprehensive Medicine, University of South Florida, Tampa

Break

Student Presentation in Occupational Medicine. (The best paper in the field of Occupational Medicine submitted by candidates in the Master of Public Health Programs at the University of South Florida. Winner and subject to be announced)

"Respiration Protection Programs, Who's in Charge?" Emmett B. Ferguson, M.D., M.P.H.

Educational Objective: To identify timely occupational medicine issues of clinical and legal importance for all physicians. To update the attendees on recent Federal and State Legislation that will impact the Doctor/Patient relationship with most of our employed patients. To familiarize physicians with efforts by the National Institute for Occupational Safety and Health to collect illness data from industrial populations. To identify essential elements of workers' compensation programs. To establish the basis for cooperative effort between occupation and private practitioners to improve the total health care system for the worker/patient. And to stimulate an interest in Statewide health education programs and continuing education opportunities in occupational medicine.

SECTION ON CLINICAL ONCOLOGY

(Co-sponsored by Florida Radiological Society, Florida Society of Clinical Oncology, and American Cancer Society, Florida Division)
Friday, May 3, 1985—1:30 p.m. to 5:00 p.m.
Robert Nuss, M.D., Jacksonville
Juan Fayos, M.D., Miami
Program Chairmen

"Carcinoma of the Head and Neck"

"Surgical Approach to Carcinoma of the Head and Neck," James R. Chandler, M.D., Professor and Chairman of the Department of Otolaryngology, Miami

"Overview of Head and Neck Surgery," Monica B. Spaulding, M.D., Associate Professor of Medicine, State University of New York at Buffalo School of Medicine; Chief of Oncology Section, Buffalo VA Medical Center, Buffalo, New York

Break

"The Role of Radiation Therapy in Head and Neck Malignancy," Rodney R. Million, M.D., Professor and Chairman, Division of Radiotherapy, University of Florida College of Medicine, Gainesville

Questions and Answers

Educational Objective: A multiple disciplinary program directed to surgeons, radiation oncologists, and medical oncologists, concerning the treatment of head and neck malignancies stressing the combined modality treatment of head and neck cancer.

SECTION ON OPHTHALMOLOGY

(Co-sponsored by the Florida Society of Ophthalmology)
Saturday May 4, 1985—9:00 a.m. to 12:00 noon
Bascom Palmer Institute
Lawrence B. Katzen, M.D., Miami
Program Chairman

"Common Eyelid Tumors and Pearls on Reconstruction," Richard R. Tenzel, M.D., Clinical Professor of Ophthalmology, University of Miami School of Medicine; Chief, Plastic Surgery Services, Bascom Palmer Eye Institute, Miami

"Blepharoplasty," J. Justin Older, M.D., P.A., Ophthalmic Plastic and Reconstructive Surgery, University of South Florida, Tampa

"Acquired Ptosis," Lawrence B. Katzen, M.D., Clinical Assistant Professor of Ophthalmology — Bascom Palmer Eye Institute, Miami

Educational Objective: This three hour symposium on oculoplastic surgery is designed to update the participants on common eyelid problems, blepharoplasty, and acquired ptosis. The lecturers will provide current state of the art information on evaluation and treatment of these problems. It is expected that at the completion of this meeting, the participants will have enhanced their ability to diagnose and manage the above described problems. In addition, it is hoped that their surgical techniques will be improved as well. There will be a total of three hours of lecture, question and answer periods, and panel discussions.

SECTION ON ORTHOPEDICS

(Co-sponsored by the Florida Orthopedic Society)
Friday, May 3, 1985—7:30 a.m. to 10:30 a.m.
Friday, May 3, 1985—1:30 p.m. to 5:00 p.m.
Saturday, May 4, 1985—7:00 a.m. to 10:50 a.m.
Ralph E. Peterson, M.D., Naples
Program Chairman
David S. Teperson, M.D., Hollywood
Local Arrangements Chairman

Session I: Friday, May 3, 1985

Wallace Miller, M.D., Miami, Moderator

Opening Remarks — Ralph E. Peterson, M.D., Naples

"Orthopedic Management of the Multiple Injured Child," Jorge Alonso, M.D., Member, Florida Orthopedic Society, Jacksonville

"Three Bone Forearm in the Adolescent — A Ten Year Follow-Up," William A. Stolzer, M.D., Member, Florida Orthopedic Society, Port St. Lucie

"Osteomyelitis of the Cervical Spine," Frank J. Eismont, M.D., Member, Florida Orthopedic Society, Miami

"Cotrel Dubousset Posterior Spinal Instrumentation, A Preliminary Report," Charles Wingo, M.D., Louisville, Kentucky

"Segmental Spinal Instrumentation in Idiopathic Scoliosis — Retrospective Analysis of 234 Cases," H.L. Shuffelbarger, M.D.; L.A. Rinski, M.D.; A. Kahn, M.D.; H. Shank, R.N., Miami

"Closed Femoral and Tibial Nailing for Non-Union and Malunion," Sigvard T. Hansen, M.D., Professor and Chairman of the Department of Orthopedic Surgery, University of Washington Medical School, Seattle, Washington

"Subtalar Dislocations: A Prognosticating Classification," Steven Lancaster, M.D.; Marshall Horowitz, M.D.; Jorge Alonso, M.D., Jacksonville

Session II, Friday, May 3, 1985

Richard M. Fry, M.D., Gainesville, Moderator

"Allergenic Transplants: State-of-the-Art and Multi-Institutional Approach," Hans Burchardt, Ph.D., University of Florida, Gainesville

"Hip Osteotomies and Arthrosis," Jeff Mast, M.D., Member, Florida Orthopedic Society, Tampa

"Cementless Revision of Total Hip Replacement," William R. Kennedy, M.D., Sarasota

"Hand Injuries in Sports," Robert S. Franco, M.D.; J.C. Crick, M.D., Jacksonville

Break

"Concepts and Considerations in Reconstructive Foot Surgery," Sigvard T. Hansen, M.D.

"Past Accomplishments of Biochemical Relationships of Osteoarthritis and Future Direction," David S. Howell, M.D., Member, Florida Orthopedic Society, Miami

"Spinal Decompression for Acute Fractures," Richard E. Strain, M.D.; Greg Zorman, M.D.; Donald Sheffal, M.D.; Donald Guilianti, M.D., Hollywood

Adjournment

Session III, Saturday, May 4, 1985

Sandy Burdett, M.D., West Palm Beach, Moderator

"Surgical Approach to Significant Low Lumbar Spinal Problems," George T.F. Rahilly, M.D., Member, Florida Orthopedic Society, Ft. Lauderdale

"Anatomic Surface Replacement Arthroplasty of the Elbow," Roland Pritchard, M.D., Member, Florida Orthopedic Society, Miami

"Pigmented Villonodular Synovitis Mimicking Internal Derangement of the Knee, Report of Three Cases," Jose E. Diaz, M.D., Member, Florida Orthopedic Society, Ft. Lauderdale

"Relationship of Soft Tissue Grading to Fixation Choices in Open and Closed Fractures," Sigvard T. Hansen, M.D.

Break

Session IV, Saturday, May 4, 1985

Richard G. Onkey, M.D., Naples, Moderator

"Primary Subacute Hematogenous Epiphyseal Osteomyelitis," Charles H. Moorefield, III, M.D.; Charles T. Price, M.D., Orlando

"Painful Foot in Relationship to Peripheral Vascular Ischemia and Presence of Normal Pulsation," Wallace Miller, M.D., Member, Florida Orthopedic Society, Miami

Educational Objective: To provide an orthopaedic, trauma, infection and reconstructive program presented in the form of 20 presentations three of which will consist of 45 minute lecture/discussions on the above topics by guest lecturer Sigvard T. Hansen, M.D.

SECTION ON PATHOLOGY

(Co-sponsored by Florida Society of Pathologists)
Friday, May 3, 1985—1:30 p.m. to 5:00 p.m.
Albert Cohen, M.D., Delray Beach
Program Chairman

"Major Problems in Pulmonary Pathology in the 21st Century," Jerome Kleinerman, M.D., Professor and Chairman, Department of Pathology, Mount Sinai School of Medicine, New York, New York

"Angitis and Granulomatosis of the Lung — A Reappraisal," Mario Saldana, M.D., Professor of Pathology, University of Miami School of Medicine, Miami

Educational Objective: Two important issues in pathology will be examined to include major problems in pulmonary pathology in the 21st century; and a reappraisal of angitis and granulomatosis of the lung.

SECTION ON PLASTIC AND RECONSTRUCTIVE SURGERY

(Co-sponsored by the Florida Society of Plastic and Reconstructive Surgery)
Saturday, May 4, 1985—9:00 a.m. to 12:00 p.m.
Lawrence B. Robbins, M.D., Miami Beach
Program Chairman

"Trends in Plastic Surgery"

"Eye Liner — Yes or No?" Alan Rapaport, M.D.

Discussion

"Complications and Treatment of Face Lifting," Charles Radlauer, M.D.

"Chest Wall Reconstruction," Thomas Zaydon, M.D.

Discussion

"Microsurgery Update 1985," Gregory Louaas, M.D.

"Ambulatory Surgical Facilities, State of the Art," Lawrence Robbins, M.D.

Educational Objective: Several current trends in the practice of plastic surgery will be examined and discussed.

SECTION ON PREVENTIVE MEDICINE

(Co-sponsored by Florida Society for Preventive Medicine)
Saturday, May 4, 1985—8:00 a.m. to 12:00 noon
Stephen H. King, M.D., Tallahassee
Program Chairman

Greetings from the Program Chairman

"Recent Advances in the Problem of AIDS," Jeffrey J. Sacks, M.D., M.P.H., State Epidemiologist, Department of HRS, Tallahassee

"Modern Epidemiology and Control of Tuberculosis," Clifford H. Cole, M.D., M.P.H., Director, Community Tuberculosis Control, Department of HRS, Jacksonville

"Decision Analysis in Public Health," Jeffrey P. Koplan, M.D., M.P.H., Assistant Director, Public Health Practice, Centers for Disease Control, Atlanta, Georgia

"Role of Toxicology in Public Health Practice," Richard W. Freeman, Ph.D., Toxicologist, Preventive Health Services, Department of HRS, Tallahassee

"Rabies in the Wildlife Environment," Faye E. Sorhage, V.M.D., M.P.H., E.I.S., Department of HRS, Tallahassee

Educational Objective: The program of the Section on Preventive Medicine is designed to provide the attendees with updated information on a series of relevant topics in preventive medicine. This information will increase the practice skills of the attendee particularly in the topics of AIDS, tuberculosis, decision analysis, toxicology, and rabies.

SECTION ON PSYCHIATRY

(Co-sponsored by Council of Florida District Branches of the American Psychiatric Association)
Friday, May 3, 1985—7:30 a.m. to 10:45 a.m.
Juan E. Rodriguez, M.D., Miami
Program Chairman

"Relevance of Dynamic Psychotherapy to Psychiatry, — Reminiscenses and Expectations," Evan Katz, M.D.

"Keeping Ourselves Emotionally Fit Under Stress," Peggy Hutson, M.D.

"Psychology and Clinical Applications," Elizabeth Gilmore, M.D.

"The Role of Psychiatry in Medical Practice," Michael Hughes, M.D.

"Physicians' Kids: Problems in the Potential," Richard Rubin, M.D.

"Forensic Psychiatry," Sanford Jacobson, M.D.

Educational Objective: To provide a comprehensive psychiatric update for the medical profession with a broad spectrum of subjects. Topics range from patient management to physicians and their families.

SECTION ON RADIOLOGY

(Co-sponsored by the Florida Radiological Society)
Friday, May 3, 1985—1:30 p.m. to 5:30 p.m.
Saturday, May 4, 1985—8:00 a.m. to 12:00 noon
Kurt W. Mori, M.D., Jacksonville
Program Chairman

Friday, May 3, 1985

"Foundations of Clinical Ultrasound," Jason Birnholz, M.D., Professor of Radiology, Rush-Presbyterian — St. Luke's Medical Center, Chicago

"Thallium Myocardial Imaging," Gordon DePuey, M.D., Associate Professor of Radiology, Emory University, Atlanta

Break

"Ultrasound Evaluation of the Fetus," Jason Birnholz, M.D.

"Gated Blood Pool Studies," Gordon DePuey, M.D.

Questions and Answers

Saturday, May 4, 1985
Introduction
"Vascular CT Imaging — Indications and Pitfalls," Stanley Rapoport, M.D., Assistant Professor of Radiology, Yale University College of Medicine, New Haven
"Radiologic Approach to the Jaundiced Patient," Kurt W. Mori, M.D., Attending Radiologist, Baptist Medical Center, Jacksonville
"Correlative Imaging in Abdominal Infections — New Concepts," Stanley Rapoport, M.D.
Questions and Answers

Educational Objective: The program is directed towards diagnostic radiologists emphasizing newer concepts in non-invasive imaging modalities.

SECTION ON RHEUMATOLOGY

(Co-sponsored by the Florida Society of Rheumatology)
Friday, May 3, 1985—1:30 p.m. to 5:00 p.m.
Mike F. Mass, M.D., Jacksonville
Program Chairman

"Factors Regulating Bone Metabolism," Lawrence G. Raisz, M.D., Head of Endocrinology and Metabolism, University of Connecticut in Farmington
"Pathogenesis Differential Diagnosis, Prevention and Treatment of Osteoporosis," Lawrence G. Raisz, M.D.

Educational Objective: To acquaint the general medical community with the general concepts of metabolic bone disease and the risk factors involved in osteoporosis as well as attempts at measurement and modification of this disease.

SECTION ON SURGERY

(Co-sponsored by the Florida Chapter, American College of Surgeons, the Florida Association of General Surgeons, and the Florida Association of Pediatric Surgeons)
Friday, May 3, 1985—2:00 p.m. to 5:00 p.m.
John O. Gage, M.D., Pensacola
Program Chairman

Resident Papers
"Natural History for Surgical Resections for Hepatic Metastases," Kirby I. Bland, M.D., Professor and Associate Chairman, Department of Surgery, University of Florida College of Medicine, Gainesville
Questions and Answers
"Regional and Systemic Management of Hepatic Metastases of Colorectal Origin," John M. Daly, M.D., Sloan-Kettering Institute
Questions and Answers

Educational Objective: To acquaint physicians and surgeons in the application and use of self-contained subcutaneous implantable continuous chemotherapeutic infusion pumps in the treatment of metastatic carcinoma of the liver, and the surgical indications and treatment of hepatic metastases.

SECTION ON UROLOGY

(Co-sponsored by Florida Urological Society)
Saturday, May 4, 1985—9:00 a.m. to 12:00 noon
Jorge L. Lockhart, M.D., Miami
Program Chairman

"Alternative Methods of Urethral Stricture Repair," George D. Webster, M.D., Assistant Professor of Urology, Duke University School of Medicine, Durham, North Carolina
"T. Leon Howard Pyelogram Hour," Ian Nisonson, M.D., Moderator

Educational Objective: Dr. Webster will talk about surgical techniques, rather than endoscopic procedures to treat urethral stricture with emphasis on skin graft and urethroplasty technique. This will be a clinical talk and will have practical information to assist the Urologist in patient care. During the Pyelogram Hour, x-rays of interesting cases will be presented by the membership and discussed in detail.

Restaruant list for dining during FMA Annual Meeting

The following restaurants provide a large variety of suggestions for dining at the FMA Annual Meeting, May 1-5, Diplomat Hotel, Hollywood. This list was submitted by Charles A. Monnin Jr., M.D., Hialeah, and compiled by Glenn Parker and Jim Hinsdale. Mr. Parker is President of the Fort Lauderdale Chapter of the Confrerie de la Chaine des Rotisseurs and is one of the contributors to *Baron's Report*. Mr. Hinsdale is a member of the Wine and Food Society of Palm Beach and President of the Chaine in Boca Raton.

Cafe September
2975 North Federal Highway
Fort Lauderdale
563-4331
Nouvelle cuisine and excellent wines. Adjoins the September nightclub. Expensive.

Casa Vecchia
209 North Birch Road
Fort Lauderdale
463-7575
Excellent Italian. Overlooks the Intracoastal Waterway.

Chuck's Steak House
(two locations)
1201 Southeast 17th Street Causeway
Fort Lauderdale
527-4400
300 South State Road 7
Plantation
584-8817
Known for its steaks and prime rib. No reservations. Excellent salad bar. A real bargain. Moderate.

The Down Under
3000 East Oakland Park Blvd.
Fort Lauderdale
563-4123
Very popular. Very good. American and European dishes. Expensive.

The French Quarter
215 SE 8th Avenue
Fort Lauderdale
463-8000
Features good basic French food, delighted decor and an upstairs bar and disco for the 30 and up age group.

Mai Kai
3599 North Federal Highway
Fort Lauderdale
563-3272
One of the nation's top purveyors of Polynesian type food. Nightly review of beautiful sarong clad girls and knife throwing strong men. Moderate.

Paesano
1301 East Las Olas Blvd.
Fort Lauderdale
467-3266
Popular Italian cuisine, good wine selection, friendly atmosphere and moderately priced. A choice of very elegant dining rooms.

Paesano's North
3850 North Federal Highway
Light House Point
942-0006

Pier 66
2301 SE 17th Street Causeway
Fort Lauderdale
524-0566
A skyscraping pause with a view of one of the world's great marinas. The elevator takes 66 seconds; the floor rotates every 66 minutes. An excellent place to begin an evening of dining. Great for cocktails. Windows on the Green Restaurant, which is not only one of the most beautiful dining rooms in South Florida, but maybe the finest nouvelle cuisine in the Fort Lauderdale area.

La Coquille
1619 East Sunrise Blvd.
Fort Lauderdale
467-3030
Fine new French Restaurant.

Umberto's
308 North Federal Highway
Hallandale
456-2110
Moderate, $15.

Rinaldo's
2705 North Dixie Highway
Fort Lauderdale
561-8129
A very small restaurant, seats only 35, with a very eclectic continental menu.

Ristorante Italiano
La Perla
1818 East Sunrise Blvd.
Fort Lauderdale
765-1950
Beer and wine.

Yesterdays
The Plum Room
3001 East Oakland Park Blvd.
Fort Lauderdale
561-4400
Lovely atmosphere. Good food. Moderately expensive. The Plum Room on top is interesting. Expensive.

La Vieille Maison
770 East Palmetto Park Road
Boca Raton
421-7370
Mobile 5 star winner and a consistent Holiday Award winner.

Roberto
640 East Atlantic Blvd.
Delray Beach
278-8351
Recently expanded due to popularity. Must try their famous crisp duck and succulent vealchop. Fresh seafood and very fine veal dishes. Moderate lunch and dinner. Closed Sunday.

The Grocery
640 East Atlantic Blvd.
Delray Beach
278-5219
California style cuisine; excellent and well-priced wine list featuring California wines. Overflowing with greenery. Casual atmosphere; filled with antiques and unusual items. Next to Roberto. Moderate.

Bali Plaza
21212 Street Andrews Blvd.
Boca Raton
391-6676
Authentic Indonesian cuisine (also good Chinese selections). Try the rijstafel. The knowledgeable and friendly owner will be glad to assist you in choosing your meal. Small wine list as beer is the preferred drink with Indonesian cuisine. Inexpensive to moderate.

Bernard's
1730 North Federal Highway
Boyton
737-2236
Continental dining in a garden atmosphere. Watch racoons come out at night! Moderate.

Brooks
500 South Federal Highway
Deerfield Beach
427-9302
Large restaurant which manages to maintain intimate atmosphere. Decent wine list at moderate to high prices. Continental cuisine, check on chef's specials.

Pals the Captains Table
Cove Yacht Basin
Deerfield Beach
427-4000
Beautiful location directly on the Intracoastal. A Deerfield institution. Fine Continental cuisine with occasional spotty service. A bit touristy, but fun. Moderate. Lunch and dinner.

Poppagallos
410 North Federal Highway
Pompano
785-4444
Excellent Italian cuisine with superb service. Check for the chef's specials, they are that. Good Italian wine list. Moderate.

Cafe Limoges
1 South Ocean Blvd.
Boca Raton
368-2474.
Features fresh seafood and veal dishes. Nice wine list. Moderate.

Arturo's Ristorante
6570 North Federal Highway
Boca Raton
997-7373
Authentic and excellent Italian cuisine. Homemade pastas. Lovely atmosphere, tableside cooking. Nice wine list. Moderate.

J T's Restaurant
4400 North Federal Highway
Boca Raton
392-4210
Authentic French atmosphere and cuisine. The young Chef's sauces are superb. Moderate to expensive.

Baan Tahi
2885 S. Federal Highway
Delray Beach
272-8326
Fine Thai Cuisine. Often features Thai dancing as the owner's wife is from Thailand and trained in the art. Beer, wine and full bar. Inexpensive to moderate.

DEAN'S MESSAGE

Green Stamps or education

The *New York Times*, on March 10, 1985, printed an article relating how college curricula through the nation are being reviewed and revised. Most colleges referenced in the article are arranging the required coursework for all students to gain a varied background and yet provide them with an in-depth experience in one discipline. One educator stated that many college curricula are like filling a "Green Stamp" book! Once the book is filled, the student graduates!

While this atmosphere of curriculum review is prevalent on undergraduate campuses, the same attitude is also present in many medical schools, including the University of Florida College of Medicine. Here in Gainesville, the medical curriculum is undergoing an intensive review by faculty, students, and alumni. Now entering the final months of the review, countless faculty from other parts of the University, as well as our own faculty, have been interviewed by the College's Curriculum Committee. Each course is critically reviewed by a team of faculty from other disciplines. When all major courses are reviewed, the Curriculum Committee will make recommendations to the entire Faculty. While no one can predict what changes will be recommended, one can be certain that the height of awareness of the the quality of instruction and the learning process is acute throughout the institution.

In late 1981, the Association of American Medical Colleges created a panel of experts to study "The General Professional Education of the Physician and College Preparation for Medicine." This three-year study was funded by the Henry J. Kaiser Family Foundation and chaired by President Steven Muller of Johns Hopkins University. The final report was released in late 1984 and is recommended for your reading. One of the conclusions this independent body made was every college and university should require each student to receive a "broad study in the natural and the social sciences and in the humanities" regardless of career objective.

Therefore, undergraduate programs and medical schools are concerned about the ability of our young people to relate to the world around them as they pursue their careers.

Since the Flexner Report in 1910, there has not been the serious reflection on the continuum of medical education as currently exists. Even with the exigencies of malpractice, reimbusement, and research

funding that seemingly dominate, your medical schools' faculties are continuing to improve the educational process . . . ultimately to improve the health of the public through better medical education.

The "Green Stamp approach" is under seige. Dr. Will Mayo wrote in 1933:

> One of the chief defects in our plan of education in this country is that we give too much attention to developing the memory and too little to developing the mind; we lay too much stress on acquiring knowledge and too little on the wise application of knowledge.

Fifty-two years later, his words are receiving attention.

William B. Deal, M.D.
Dean, College of Medicine
Associate Vice President
for Clinical Affairs
University of Florida

WORTH REPEATING

Employing the older worker

It is a pleasure to be here today and to share with you my experiences with issues of employment of the older and the disabled worker.

My experience is that of a neurologist and I am involved with the neurologically disabled and their employment. I am working primarily with the disease model.

The relationships between employment, health and well being are of extreme importance. If one is in poor health it may lead to temporary or permanent unemployment. Similarly employment is important to the well being or health of the individual. Unemployment may lead to poor health and loss of self esteem. Sigmund Freud, when asked to define emotional maturity and good health, replied it is the ability to work and to love. The relationship of work to well being and vice versa are undisputed.

Today I plan to speak of the relationship of employment to good health and also I plan to discuss the importance of maintaining the good health of individuals, especially the elderly, by maintaining their employment; also I plan to disucss some ways how this might be accomplished.

The relationship between employment and well being is important to a broad group of individuals. It has a major sociological, psychological, economic, and political implications.

Indeed, the "world of work" is a critical function for men and women, for young and old, for the able and the disabled. I think it is important to recognize this generic importance of employment in order to mobilize as wide a political base for essential institutional changes in employment practices.

To illustrate the potential for a broad political base, I will quote from a recent New York Times article. "Someone is going to have to do battle in a new and serious way. . .Imaginative thinking should be done about. . .reduced schedules, flex-time, (and) job sharing. . .But who will take up this battle, and how, in a time where jobs themselves are so scarce that people must take what they can get, when budgets for social programs that already exist are being cut down?" This quote is from an article by Betty Friedan addressed to issues confronting the working women.[1]

Contrary to what might be supposed, the relationship between health and retirement lends itself to no easy description. At the outset, it is important to recognize that health changes may be a cause as well as a result of retirement, that age of retirement is more flexible than often suspected, and that beliefs about health may be more important to functioning that are objective indices of health.

Age of retirement, usually an individual's 65th birthday, has been changing dramatically. At the turn of the century, retirement as we know it, did not exist in the United States. Two out of three men aged 65 and older worked compared to one in five by today. In 1950, almost one half of men aged 65 and older were in the labor force. Private pensions and social security benefits had made retirement possible for most people. However, a long period of relatively stable prices and increased levels of post-retirement support under the Social Security Act and broader pension plan provisions began to encourage the exit of working people at age 65 and earlier. In the period 1950 to 1980 labor force participation of men 65 or older dropped from 45 percent to 19.1 percent. From 1960 to 1980 labor force participation of men 55 to 64 dropped from 86.9 percent to 72.3 percent. For women the reverse trend has been occurring, with participation of those aged 55 to 64 rising from 37 percent to 43 percent during 1960's. (Kieffer, 1982; Robinson, 1982.)

Modern research is demolishing many myths about aging — that the abilities of older people invariably are in serious decline, that older workers are slow learners, that their minds do not function well, that they are disengaged and apathetic, that they are frail and unable to stand stress, that they "cause problems" for employers and are no longer productive. These generalizations are harmful and counterproductive. New knowledge about this very rapidly growing segment of the population suggests

that all American institutions, government, business and labor, should re-examine many traditional attitudes and beliefs. The growing body of evidence indicates that, far from presenting a "problem" for the nation, the elderly present the nation with a golden opportunity. Instead of being a liability, older people are a valuable human resource that America can no longer afford to waste. Age is the only condition toward which we are bigoted yet to which we all desperately aspire.

The predominant myth that old age is nothing more than a period of functional loss is bolstered by a misinterpretation of the fundamental biological fact that aging is accompanied by the loss of body cells. It is known, for example, that the number of cells in the brain does decrease with age. What is all too often ignored, however, is the great redundancy of brain cells. There is an over-supply of billions of nerve cells so that their loss through life is not at all synonymous with a loss of mental ability. Furthermore, experience is a major offset even to physiologic loss, e.g., consider the use of older astronauts in this regard. What is more important in determining the functional ability of an older person is not how many cells a person has lost over a lifetime, but rather what is functionally present. Since individuals vary greatly in the rate at which they lose this normal function, it is simply inaccurate to regard all old people as being in a process of rapid decline and diminishing usefulness.

An especially pernicious myth is that senile dementia and other diseases are inevitable if one lives long enough, for it implies that older workers must be taken out of the labor force before they "make a mess of things." It is true that many diseases are more common among older people, but these are by no means inevitable for the majority of older workers and it must be recognized that a strong tendency exists for older workers to select themselves for retirement when they do not feel well, provided they can afford to retire. There simply is no biological basis for mandating retirement for all who reach a certain age. It is productivity, not gray hair and wrinkles, that needs to be examined.

Another myth is that old people are unable to handle stress. It is important for managers to remember that older people are survivors, indeed their survival attests to their ability to manage stress successfully. Their experience, in many ways, allows them to deal more successfully with the stresses of life than younger persons.

If the nation persists in believing old myths, seeing older people in a negative light, not using them productively, and putting them "on the shelf" merely because of age, nearly one in five Americans will be dependent, or close to it, in a few decades, and a major shift of resources will be required to care for them. Already, health care costs in the United States are over 10 percent of the gross national product (most of the costs are for hospital care), and the elderly account for a disproportionate share.

It is, therefore, naive for corporations which are contributing vast sums directly to health benefits and to other human services through taxation, to think they do not have a stake in the costs of maintaining the health and productivity of an aging population. Industry can either develop plans to make productive use of older people, or pay more taxes so that governments can care for them. In either case, the corporation has to pay.

Traditions of the private sector that are barriers to the effective use of older people must be examined. One such tradition is the view of corporate life as a "ladder" to climb: early in life one gets onto the bottom rung and moves upward, only to fall off when the top is reached and never to be heard from again. A "lattice" might be considered as a more appropriate model for an aging workforce. A lattice, by allowing movement in all directions on the basis of an individual's changing interests, abilities, and talents, would allow maximum individual growth and contribution while minimizing the impact of negative stereotypes.

Another important role of the older worker in the corporate setting that can be enhanced is that of teacher and role model for younger workers. A thorny question is involved in using an older worker; however, can a worker whose primary loyalty mat be to a union also function comfortably in the role of socializing younger workers to the values and needs of the corporation? The answer depends on how well management and labor can cooperate in dealing with the issue of loyalty to whom and for what purpose.

Older workers need continuing education and training to stay productive. Though they are a repository of vast experience and talent, we concentrate all of our education and training resources on the young. In doing so, we push older people out of the central information pool and, thereby, create a kink of forced obsolescence. This pattern is as wasteful as buying a new car, filling the tank with gasoline, then abandoning the car when it is "broken in."

Another important task corporations should consider is preserving older workers' identification with the corporation after retirement — by preparing them for retirement, even offering them training for other occupations and then using this talent pool on a fee-for-service basis.

Negative stereotypes about older workers, our American "youth culture," and traditional hiring practices that discriminate against the elderly are among the major forces that tip the scale toward restraining the extension of working life. However, several powerful forces are at work that are likely to alter the balance in the other direction. These include the rapidly rising cost of Social Security, and

the need for corporations to retain the talents of older workers by keeping them on the job.

The cultural stereotype of the older person as helpless, hopeless, and decrepit is a form of bigotry. As with the racism, the damage arises not only from what the majority feel about the minority, but from what the minority are made to feel about themselves.

The stereotype is self-fulfilling: Older people accept the prevailing myths that they are infirm, that they can only deal with their problems medically, that they have to function in ways that make them seem old. Corporate leaders have bought the myths of "agism" too although the psychological mechanisms of denial usually prevent individuals from applying such beliefs to themselves ("everybody is alike except I'm different"). We must all realize that by perpetuating "agism" we, too, are likely to become its victims, if we live too long.

This approach should not be considered "pie in the sky." The demographic and economic changes are highly predictable, at least for the next three or four decades. The data are there, and the alternatives may be readily ascertained by anyone with wisdom to address the issues. We either face the significant personal and social problems of a burdensome and dependent older population or we alter our way of doing business to position ourselves to deal with the changing population and the opportunities it presents. Once again, the choice is in our hands.

Our propensity to label things is an example of such a tendency. Thus, we use sex, race, and age as convenient tags for certain situations but often these get involved in regulations or particular styles of operation. We then look at any deficits of the individual and we label him or her on the basis of the deficit, thus somebody is blind, deaf, paralyzed, mentally retarded, old.

The problem is, of course, that the overattentiveness to the disability as often as not obscures the person's ability. A man or a woman in a wheelchair can be a most effective worker if we can slightly alter the environment to give them access to the job, for example, to the worktable, desk or machine. While different sites may prevent a specific individual from performing certain activities of daily living individual is not impaired so far as other work functions may be concerned. I am raising this point because I think functional age is an important approach to a problem but I would like to take it even a step further and ask how old is old for what purposes?

Thus, greater specificity and a better fit between the functional ability and the specific needs to be addressed is a very salient point and become more and more important as we begin to look at this ageless society.

The concept of age itself is modifiable by recognizing that nearness to death is another way to look at the problem. Thus, two individuals at the same age, for example 35, may vary in nearness to death by a factor of severalfold. For one, their cardiovascular state may lead to death within just a few years, for another an additional half century of productive life may be more possible.

This idea of judging a person by health, ability, experience, and productivity, not the age, must pervade our society. It should become a major priority for research particularly as we address the notion of age as being irrelevant in the workplace.

The requirements of the job and the effects of needs are also subjects to be considered in asking the question how old is old and for what purpose?

Morgan Lyons, the director of the California Research Center has spoken of the Opportunities and Challenges of employing the older worker.

For employers, in employing the elderly, the opportunities are:

(1) A more efficient and productive workforce;

(2) Higher employee morale and loyalty among all workers;

(3) Less turnover, and more worker reliability; and

(4)More workfoce stability and continuity.

For the older worker the opportunites are:

(1) Economic well-being;

(2) Enhanced sense of self-esteem and purpose;

(3) Creativity and sense of accomplishment;

(4) Contribution to family, community and society.

For society the opportunities are:

(1) More appreciation of the contributions of older citizens, both workers and non-workers;

(2) Less conflict between young and old, in and outside the workplace; and

(3) More self-sufficiency of the "dependent" population.

In employing the older worker the challenges for the employer are:

(1) Institute age bias-free personnel practices in retaining, hiring, assessing or assigning employees;

(2) Design just and flexible health and pension benefit packages;

(3) Expand work options for all employees to include part-time, shared jobs, flex-time, job redesign, reassignment and phased retirement;

(4) Use older workers to train and as role models for other workers;

(5) Offer retirement counseling that stresses pay options, and disadvantages of retirement; and

(6) Increase employer's responsibility to their retirees.

For the older worker the challenges are:

(1) Keep skills and knowledge current;

(2) Rethink the balance between work "retirement" and other pursuits so they are seen as more compatible;

(3) Advocate for more options in work and leisure activity; and

(4) Take fuller advantage of available work and other options.

For society the challenges are:

(1) Enact and enforce age-neutral laws and regulations;

(2) Re-educate ourselves about aging, work, and the contributions and needs of the older populations; and

(3) Encourage information, compassion and action to serve the mutual needs of all groups seeking employment.

Now that we have discussed employing the older worker in general terms, it is important to comment on what each individual can do to maintain or attain the "employed status."

There are two guidelines. Education is extremely important at all stages and it is never too early to begin.

Not enough importance can be placed on education at all ages as factor in employment. With the increased level of technology, computers, and robots, getting and retaining a job is directly proportioned to the level of education. In all age groups over 25 through 65 years, the employee with at least one year of college education has almost double the chance of employment compared to those with only a grade school education. From age 65, it is a threefold advantage.

Looking at educational advantages another way, in the male 58 through 64 year age group, 90% of the professional occupations are still in the work force while only 70% of the unskilled labor occupations are in the work force. These statistics reflect the importance of education before entry into the labor force.

What can the employee do after entry into the labor force to prepare for that critical period when options are job retention, part-time work through job sharing or flex-time, or retirement.

The first and perhaps most important task is health maintenance. The worker should strive for good health habits with limited use of alcohol, tobacco, or drugs, regular exercise, weight control, and proper diet. Regular health checkups and treatment of chronic illnesses such a hypertension, diabetes, emphysema, obesity, arthritis, and heart disease. These measures should begin as early as possible.

Counselling programs for emotional problems and stress should be available and utilized. Corporations should provide this to assist in worker adjustment and satisfaction with the job. There is no need as Thoreau stated for one to live a life of quiet desperation. The employee who enjoys his task obviously performs better whereas the dissatisfied worker who can't wait to retire and whom the employer looks forward to this date even more so often has a career long history of adjustment problems. Off job marital stresses, etc. also cause poor performance and bad work habits and counselling should be available, even obligatory.

The second task is career maintenance. As technology advances, the worker should have continuing education to keep abreast to avoid obsolescence. Training the proven experienced worker is as important as that of the potential worker. Corporations should consider investment in worker improvement more valuable than capital improvements, and it should be mandatory that this be supplied. For the new worker and those seeking reentry, government should provide.

Counselling and training for lateral movement should be provided by employers. As the worker changes interests and abilities, the job must be changed and the worker prepared for this. Even posttime employment later in a different area may be considered with workers forming a pool of talent of the corporation to be used on a fee for service basis.

Finally if retirement is the choice, then planning is essential to ease the adjustment. One must prepare the workers and their families for the economic, social, and psychological impact. Retirement may be more stressful than the job ever was.

In conclusion, I would like to suggest that preparation for gainful employment of retirement begins in childhood. As Wadsworth stated beautifully:

My heart leaps up when I behold
A rainbow in the sky:
So was it when my life began;
So be it now I am a man;
So be it when I shall grow old or let me die.
The child is the father of the man
And I could wish my days to be
Bound each to each by natural piety.

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Yeshiva University
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Reprinted with permission from the authors, and was presented by Dr. Scheinberg at the Older Worker Seminar, March 11, 1983, in Hollywood, Fl. Also printed in the *Congressional Record*, May 10, 1983.

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappro-

priate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"The hyperactive child scam"

Investigations in the Kanas City and Columbia, Missouri areas have uncovered a very complex and organized new scam. Welfare and Medicaid recipients, having as many as six or seven children, were presenting these children to physicians as having Attention Deficit Syndrome. The parents explain that their children were previously treated by a physician who had left the area and the physician had prescribed 20 mg RITALIN, usually 120 mg every 30 days.

Many of the involved physicians questioned the dosage and quantity, and immediately became suspicious. The Bureau of Narcotics and Dangerous Drugs (BNDD) received complaints for several physicians stating that these "parents" were threatening both them and their office staffs.

One enterprising physician, convinced that a scam was being perpetrated, asked his wife to verify the patient's stories. The wife quickly discovered that many of the children did not attend the schools reported. Of the 45 children presented to this single physician as having Attention Deficit Syndrome, only two were found to be attending school and requiring medication.

Interestingly, in the above case, several of the patients (parents) were given prescriptions for 5 mg and 10 mg RITALIN, instead of the requested 20 mg. On several occasions the parents refused the lower dosage prescriptions, or did not return for further treatment. Apparently it is more difficult to sell the 5 and 10 milligram tablets.

Caution • Physicians are cautioned to make their own diagnsois of patient complaints and problems. Current information on Attention Deficit Syndrome indicates the child's teacher is the most important source of information on the child's behavior and possible need for medication. Also, 20 mg RITALIN is currently one of the most highly abused controlled drugs. Be alert for patients seeking help for hyperactive children and who: (a) are unknown to the physician, (b) demonstrate behavior normally associated with drug abusers, (c) have insufficient identification, or (d) otherwise appear suspicious.

A request for positive identification and/or a telephone call or two can be an effective deterent to such scams.

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

Author Responsibility. The author is responsible for all statements made in his work, including changes made by the copy editor. Manuscripts are received with the understanding that they are not simultaneously under consideration by any other publication. Rejected manuscripts are returned to the author. Accepted manuscripts become the property of *The Journal* and may not be published elsewhere without permission from the author and *The Journal*.

Each of the following should begin on a new page: abstract, first page of text, legends for illustrations, tables and acknowledgements. Each page should include a running head and surname of senior author.

Abstract. All scientific manuscripts should include a 150 word, maximum length, abstract which is a factual (not descriptive) summary of the work. This replaces the summary and precedes the article.

Title should be short, specific, clear and amenable to indexing.

List affiliations for each author. If author's present affiliation is different from affiliation under which the work is done, both should be given.

References. The following minimum data should be given: names of all authors, complete title of article cited, name of journal abbreviated according to *Index Medicus*, volume number, page numbers and year of publication. All references must be cited in the text and should be arranged according to order of citation and numbered consecutively. If references are too numerous, the editors reserve the right to eliminate with notation. "References are available from the author(s) upon request."

All accepted manuscripts are subject to copy editing. Authors receive a galley proof for approval before publication. No changes are accepted after galley is returned. Forms for ordering reprints are included with the galley proofs.

Illustrations. Illustrations are all material which cannot be set in type such as photographs, line drawings, graphs, charts and tracings. The entire cost of reproducing color illustrations is the responsibility of the author(s). Omit all illustrations which fail to increase the understanding of the text. Drawings and graphs should be done with India ink on white paper. Select overall proportions appropriate for material presented and sufficient for reduction, if necessary. Each illustration should be numbered and cited in the text. Legends should be typed and double-spaced on a separate sheet of paper. The following information should he typed on an adhesive strip and affixed to the back of illustration: figure number, title of manuscript, name of author and arrow indicating top. Tables should be self explanatory and should supplant, not duplicate, the text. Number tables consecutively, beginning with 1. Each table must have a title.

Permission letters must accompany patient photos whenever there is a possibility of identification. Prepare in accordance with state laws and specify authority to publish.

Letters submitted for publication should be designated "For Publication."

When received, the senior author will be sent an acknowledgement of receipt and a copyright agreement which must be signed by all collaborators. Should the article fail to be accepted for publication, the agreement will be returned.

BALANCED CALCIUM CHANNEL BLOCKADE!



Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

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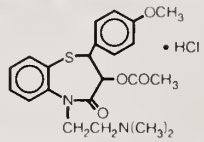
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PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral/LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/

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ibuprofen, Upjohn

600 mg Tablets



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J-4044 January 1984



"When it comes to cardiovascular medicine, I like to know exactly what my patients are swallowing."

There are doctors who say that generic drugs have a place in their practice—but not necessarily in the treatment of serious or potentially life-threatening disease. And when they consider that the average patient pays only about 45¢ a day for INDERAL (propranolol HCl) Tablets, there's not much left to discuss.

When it's INDERAL Tablets you want for the treatment of hypertension, angina, arrhythmias, or post-MI patients, make sure you specify "Dispense As Written" (DAW), "Do Not Substitute," or whatever is required in your State. That way, you'll know exactly what your patients will get.

Please see next page for brief summary of prescribing information.

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BRAND OF PROPRANOLOL HCl
Small price to pay.

"When it comes to cardiovascular medicine, I like to know exactly what my patients are swallowing."

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10 mg 20 mg 40 mg 60 mg 80 mg 90 mg*

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERAL® (propranolol hydrochloride) Tablets

CONTRAINDICATIONS

INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL

WARNINGS

CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL, like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS

General Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL (propranolol hydrochloride) may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory bronchospasm.

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

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Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

Parenting: skills and smiles

It was her first smile! What a blessed relief it was to her children who lingered long and lovingly at the bedside of their mother awaiting the outcome of her most recent stroke.

How often she had smiled at our first steps, at our first feeble attempts to feed ourselves, the first spoken words, our first efforts to dress ourselves, and through the years, she smiled often, sometimes frowning, as we grew up reaching for the stars.

Aging brought with it the problems associated with diminishing eyesight, altered hearing, and slower steps. Coping with the reality of a changing lifestyle meant shorter shopping trips, smaller appetites, fewer holiday outings, greater emotional hurdles, and frequent medical appointments. She knew she was getting older and smiled as she quoted that well-known verse: "Everything hurts, and what does not hurt, does not work! Your little black book contains only names ending in M.D.! You get winded playing cards, you look forward to a dull evening, your knees buckle and your belt will not, your back goes out more than you do, and you sit in a rocking chair, but cannot get it going.

Auxiliary programs are available to help both parents and children. Parents are encouraged to develop parenting skills which are essential to nurturing, teaching, and protecting their children in their emotional and physical development. Parents can make all the difference when it comes to the health and happiness of their children. Children can make all the difference to the health and happiness of their parents in their golden years.

The Auxiliary offers community service projects in Parenting and Safety. Auxilians are urged to participate and each Auxilian may become a S.T.A.R. (Safety Through Auxiliary Resources). Also, Auxilians continue to promote programs for our aging population, and for older persons who are confined to care centers or their homes. Positive efforts as volunteering in nursing homes and hospitals can strengthen the dignity of our aging citizens — our parents. Activity can be a lifesaver and stave off the depression often accompanying the aging process. There is no greater satisfaction than knowing that we have done all we could to enrich the lives of those we love, and to reach out into the community to improve the quality of life for all our citizens.

Young parents and aging seniors need all the positive reinforcement we can muster. Auxilians are committeed to meeting the needs of this large segment of our population, and are answering the call in unique ways best suited to their own communities. Ideas and projects are spreading throughout the state. For help and information, contact the Auxiliary State Chairman on Aging, Mrs. Fred Swing; For Parenting and Safety contact Mrs. Paul Flaten.

"It was her first smile; a smile that fills my life with sunshine, and will always be remembered long after the skills have vanished." Our parents cared for us in our youth; let us not forget them in their golden years. Promote and participate in programs for our aging seniors and our young parents. We need them both, and they need us. One is fulfillment, the other is the hope and promise of the future.

Mrs. Walter (Isabella) Laude
Babson Park

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Involving patients in these types of activities is just one example of the full-service treatment pain sufferers are receiving at the Pain Management Unit at University Community Hospital.

Our treatment is a smart choice for the patient and the physician. Because sometimes you've done all that can be done to alleviate the pain, yet the patient still suffers.

That's when you need to refer your patient to a professional pain rehabilitation center, one which specializes in pain management. The Pain Management Unit at University Community Hospital is such a place.

The unit focuses on five major areas of pain rehabilitation: the actual reduction of pain; decreasing medication levels; increasing daily activities to improve the quality of life; the reduction of stress; and vocational counseling.

The unit's In-Patient Clinical Program involves eight critical areas of pain management, each with its own set of special techniques and goals: medical management, physical therapy, occupational therapy, social service, rehabilitation counselors, nursing, psychology, and recreational therapy.

For referral information please call (813) 972-7253, collect, or write to us at 3100 E. Fletcher Avenue, Tampa, Florida 33612.



Pain sufferers use biofeedback to monitor their stress levels.



Simple activities help the patient regain dexterity.



In Occupational Therapy, patients are taught to complete everyday tasks that have become difficult.



Patients use the whirlpool tank to relax muscles.



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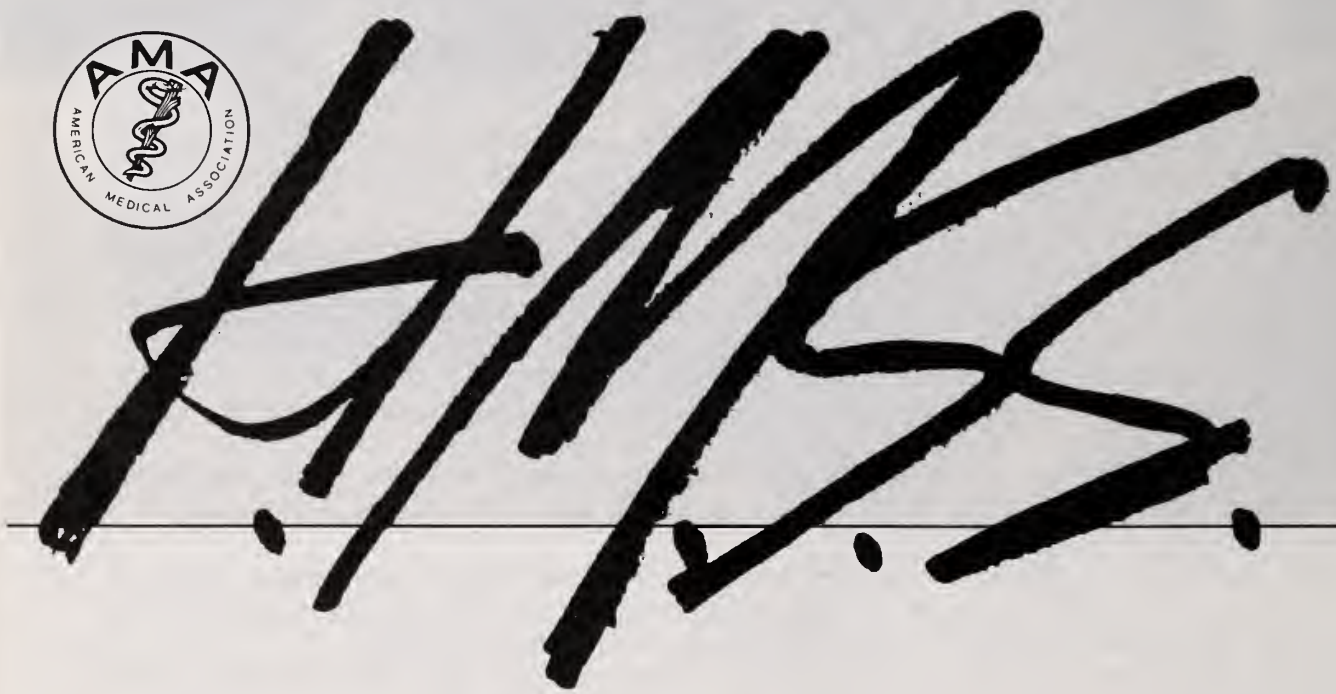
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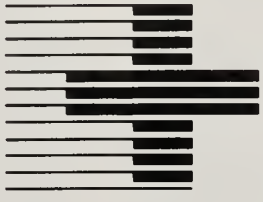
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Meetings

Accepted by the FMA Committee on Continuing Medical Education for Mandatory Credit

MAY

Correction of Maxillo Facial Deformities, May 10-16, Sheraton Bal Harbour, Miami. For information: ACPA, National Office, 331 Salk Hall, Univ. of P. H., P.H., PA 15261, 412-681-9620.

Current Concepts in Pain Management, May 10-29, Mississippi Steamboat Cruise. For information: Dr. Berman, 3301 Johnson St., Hollywood 33021, (305) 989-6650.

Flexible Sigmoidoscopy, May 11, JFK Memorial, Atlantis. For information: Fred R. Smith, M.D., 110 JFK Circle, Atlantis 33462, 305-964-8221.

Adolescent Pregnancy - Problems & Solutions, May 17, Palm Beach Airport Hilton, West Palm Beach. For info: Becky Myers, 5312 Broadway, West Palm Beach 33407, (305) 848-6300.

2nd Annual Lykes Cancer Center Symposium, May 17-18, Holiday Inn Surfside, Clearwater Beach. For info: Roger Lapp, P.O. Box 1027, Clearwater 33517, 813-443-1081.

Forum on Colorectal Cancer, May 23, University Centre Hotel, Gainesville. For info: Burta Messenter, University of Florida, Gainesville 32610, (904) 392-4321.

Master Approach to Cardiovascular Problems, May 25-27, Contemporary Hotel, Orlando. For information: Yolanda M. Barcena, Dept. of Medicine/Cardiology, University of Miami, Miami 33101, (305) 549-7124.

Review Course for Certification in Internal Medicine, May 26-31, Key Biscayne Hotel, Key Biscayne. For info: Jose S. Bodes, M.D., P.O. Box 016960, Miami 33101, (305) 547-6063.

American Academy of Clinical Anesthesiologist 1985, May 29-June 1, Destin Hilton, Destin. For information: Donald Catron, M.D., P.O. Box 11619, Knoxville, TN 37939, 615-588-6279.

JUNE

Neonatal & Pediatric Respiratory Disease Conference, June 6-9, Sheraton-Sand Key Resort Hotel, Clearwater Beach. For information: Myrtle Larson, R.N., Gulf Coast Lung Assn., 6160 Central Ave., St. Petersburg 33707.

American & European Views on Critical Care, June 8-15, Cannes, France. For info.: Sonja Craythorne, Dept. of Anesthesiology, Univ. of Miami, Miami 33101, (305) 547-6411.

Coronary Artery Disease and Sudden Death: Primary and Secondary Prevention, June 14-16, Hyatt Grand Cypress, Orlando. For information: Margaret Kleiger, 64 Inverness Dr. E., Englewood, CO 80112, (303) 790-8445.

Emergency Care: The Pediatrician's Turf, June 15-19, Sheraton Sand Key Hotel, Miami. For info: Gilbert Pitisci, 2902 Beach Drive, Tampa 33609.

10th Annual Florida Suncoast Pediatric Conference, June 15-19, Sheraton Sand Key Hotel, Clearwater Beach. For information: Gilbert Pitisci, M.D., 2902 Beach Dr., Tampa 33609, (813) 870-3720.

Advances in Internal Medicine, June 23-28, France. For information: Div. of CME, P.O. Box 016960, Miami 33101, 315-547-6716.

JULY

Vascular and Pulmonary Disease: Diagnosis and Management, July 26-28, Orlando Hyatt, Kissimmee. For information: Stephen Mattingly, 5808 S. Rapp Street, Littleton, CO 80120, (303) 798-9682.

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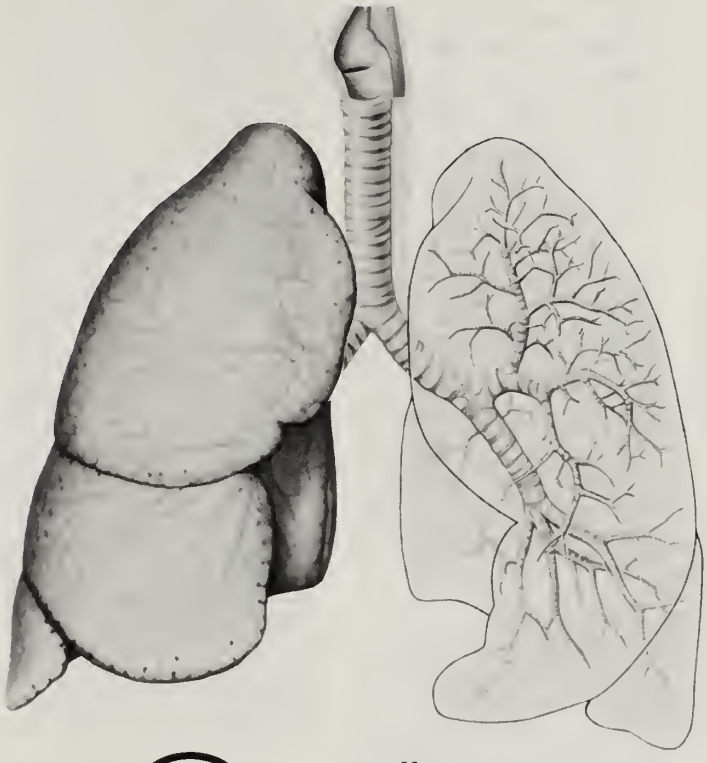
I. **Basics of Radiological Protection** (Credit: 8 hours)
Course dates: Saturdays April 20, May 18, June 15 and July 13

II. **Biological Effects of Ionizing Radiation** (Credit: 4 hours)
Course dates: April 27, May 24, June 22 and July 20

III. **Parameters Affecting Performance of General Purpose Radiographic Systems** (Credit: 4 hours)
Course dates: April 27, May 24, June 22 and July 20

For registration and other details, write or call:
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36 Via De Casas Norte, Boynton Beach, Fl. 33435
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offers effectiveness against the major causes of bacterial bronchitis

H. influenzae, H. influenzae, S. pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: *General Precautions* — If an allergic reaction to Ceclor* (cefaclor, Lilly) occurs, the drug should be discontinued and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — Pregnancy Category B — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor* (cefaclor, Lilly). There are however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below:

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbiliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Ceclor* (cefaclor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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FAMILY PRACTICE OR EMERGENCY MEDICINE physician opening in a private freestanding emergency center. Excellent location. Highly attractive practice setting. Send CV to: Michael J. Webb, M.D., Harrell Medical Center, 1805 SE Lake Weir Avenue, Ocala, FL 32627 or call (904) 629-0642.

GERIATRIC OR FAMILY PRACTICE physician wanted in Central Florida. Ideal practice situation. Reply to: C-1202, Post Office Box 2411, Jacksonville, FL 32203.

GENERAL INTERNISTS, PEDIATRICIANS,AND FAMILY PRACTITIONERS: Expanding 30 man physician multispecialty group in West Palm Beach, Fla. seeks dynamic, Florida licensed, fully American trained physicians for private practice 1985. Candidates must be personable and well qualified; emphasis on high quality patient care. Send CV and references with letter outlining your goals to: C-1249, Post Office Box 2411, Jacksonville, Fl 32203.

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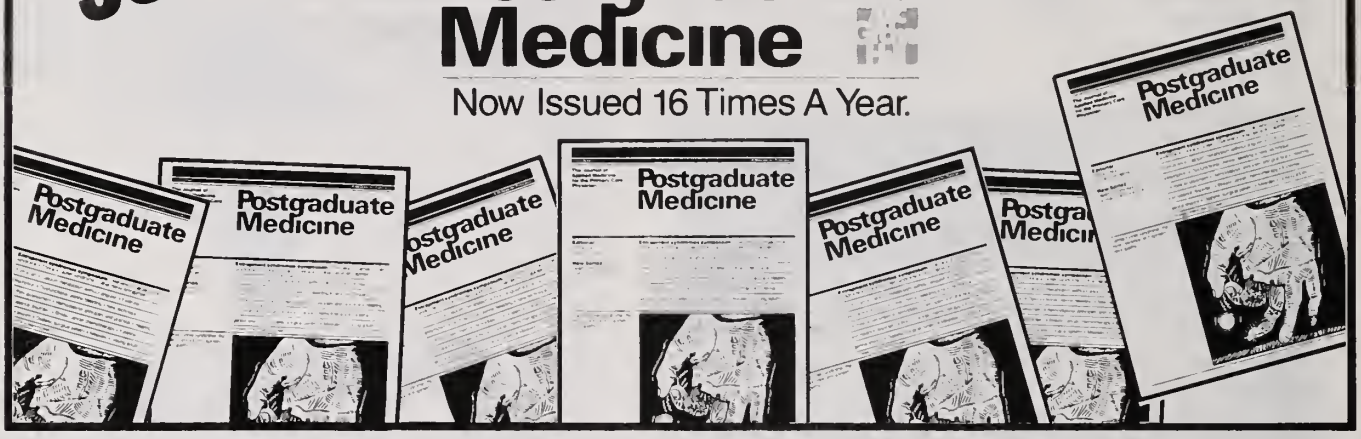
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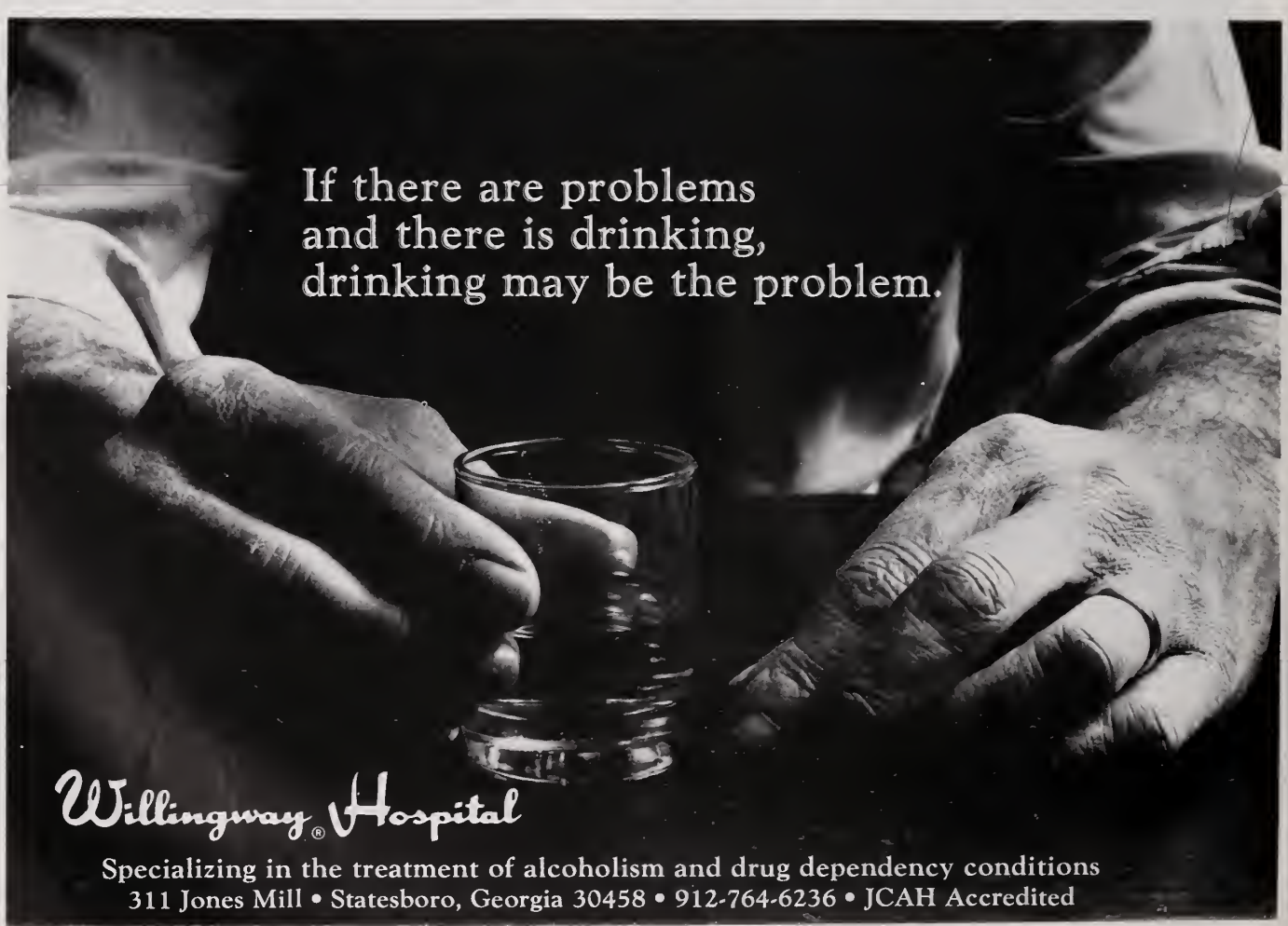
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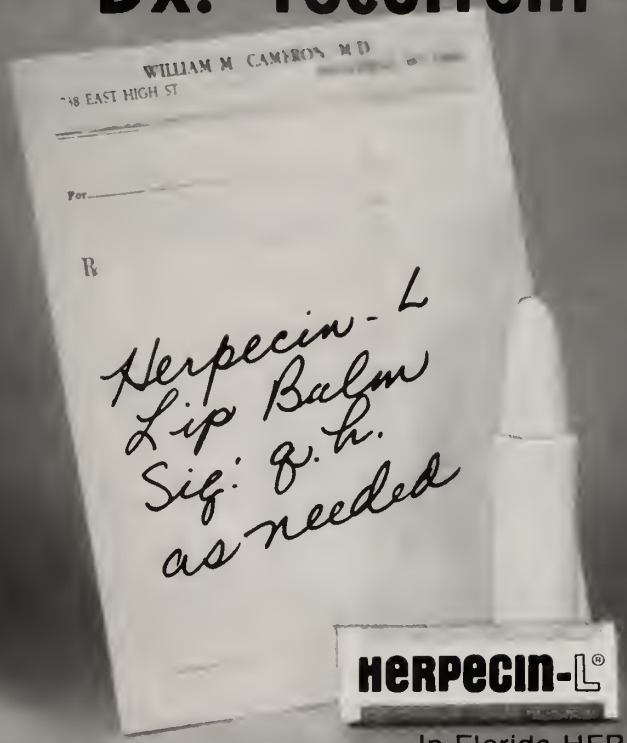
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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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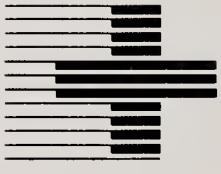
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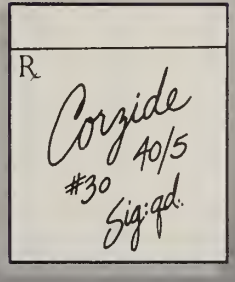
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*Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure. The 1984 report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure. Arch Intern Med 144:1045-1057, 1984.

Please see brief summary of prescribing information on following page

CORZIDE®

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Nadolol-Bendroflumethiazide Tablets

DESCRIPTION: CORZIDE (Nadolol-Bendroflumethiazide Tablets) for oral administration combines two antihypertensive agents: CORGARD® (nadolol), a nonselective beta-adrenergic blocking agent, and NATURETIN® (bendroflumethiazide), a thiazide diuretic-antihypertensive. Formulations: 40 mg and 80 mg nadolol per tablet combined with 5 mg bendroflumethiazide.

CONTRAINDICATIONS: Nadolol — Bronchial asthma, sinus bradycerdia and greater then first degree conduction block, cardiogenic shock, and overt cardiac failure (see WARNINGS). **Bendroflumethiazide** — Anuria, and in those with previous hypersensitivity to bendroflumethiazide or other sulfonamide-derived drugs.

WARNINGS: Nadolol — Cardiec Fellura — Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta-blockade may precipitate more severe failure. Although beta-blockers should be avoided in overt congestive heart failure, if necessary, they can be used with caution in patients with a history of failure who are well compensated, usually with digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle. IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta-blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, digitalize and/or give diuretics, and closely observe response, or discontinue nadolol (gradually, if possible).

Exacerbation of Iachemic Heart Diseese Following Abrupt Withdrawal — Hypersensitivity to catecholamines has been observed in patients withdrawn from beta-blocker therapy; exacerbation of angina and, in some cases, myocardial infarction have occurred after *abrupt* discontinuation of such therapy. When discontinuing chronic use of nadolol, particularly in patients with ischemic heart disease, gradually reduce dosage over a 1- to 2-week period and carefully monitor the patient. Reinstitute nadolol promptly (at leest temporerily) and teke other measures appropriate for management of unstable angina if angina markedly worsens or acute coronary insufficiency develops. Warn patients not to interrupt or discontinue therapy without physician's advice. Because coronary artery diseese is common end may be unrecognized, it may be prudent not to discontinue nadolol therepy abruptly even in patients treated only for hypertension.

Nonellergic Bronchospesm (e.g., chronic bronchitia, emphyseme) — PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA-BLOCKERS. Administer nadolol with ceution since it may block bronchodiliation produced by endogenous or exogenous cetecholamine stimulation of beta, receptors. **Major Surgery** — Beceuse beta blockade impairs the ability of the heart to respond to reflex stimuli and mey increase the risks of general anesthesia and surgical procedures, resulting in protracted hyptension or low cardiac output, it hes generally been suggested that such therapy should be withdrawn several days prior to surgery. Recognition of the increesed sensitivity to catecholamines of patients recently withdrawn from beta-blocker therapy, however, has made this recommendation controversial. If possible, withdrew beta-blockers well before surgery takes place. In emergency surgery, inform the enesthesiologist thet the patient is on beta-blocker therapy. Use of beta-receptor agonists such as isoproterenol, dopamine, dobutamine, or levarterenol can reverse the effects of nadolol. Difficulty in restarting end maintaining the heert beat has also been reported with beta-adrenergic receptor blocking agents. **Diebetes end Hypoglycemie** — Bete-adrenergic blockade may prevent the appeerence of premonitory signs and symptoms (e.g., tachycardie and blood pressure changes) of acute hypoglycemia. This is especially important with lebile diabetics. Beta-blockade also reduces release of insulin in response to hyperglycemie; therefore, it may be necessery to adjust dose of antidiabetic drugs. **Thyrotoxicosis** — Beta-adrenergic blockade may mask certein clinical signs (e.g., tachycardia) of hyperthyroidism. To avoid abrupt withdrewel of beta-adrenergic blockade which might precipitate a thyroid storm, carefully manage patients suspected of developing thyrotoxicosis.

Bendroflumethiazide — Use with caution in severe renal disease. In patients with renal disease, azotemie may be precipitated. With impaired renal function, effects of the drug may be cumuletive. Use with caution in impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. Possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

PRECAUTIONS: General — Nedolol — Use with ceution in patients with impaired hepatic or renal function (see DOSAGE AND ADMINISTRATION).

Bandroflumethiazide — At appropriate intervals, perform serum electrolytes determination to detect possible electrolyte imbalance warning signs of which ere dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and G.I. disturbances such as nausea and vomiting. Observe patients for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Drugs such as digitalis may influence serum electrolytes. Hypokalemia may develop, especially with brisk diuresis, in presence of severe cirrhosis. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Response of the heart to toxic effects of digitalis can be exaggerated with hypokalemia. Use potassium supplements such as high potassium foods to avoid or treat hypokalemia. Any chloride deficit is generally mild and usually does not require specific therapy except under extraordinary circumstances (as in liver or renal diseese). Dilutional hyponatremia may occur in edematous patients in hot weether; appropriate therapy is weter restriction rather than salt administration except in rare instances when the hyponatremia is life threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain thiazide-treated patients. Latent diabetes mellitus may become manifest during thiazide therapy. Antihypertensive effects of bendroflumethiazide may be enhanced in the postsympathectomy patient.

Careful reappraisal of therapy and consideration given to withholding or stopping diuretic therapy is necessary if rising nonprotein nitrogen or BUN (indicative of progressive renal impairment) occurs. Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Thiazides decrease calcium excretion. Pathologic changes in parathyroid gland with hypercelcemia and hypophosphatemia have been occasionally observed with prolonged therapy. Common complications of hyperparathyroidism have not been seen.

Information for Patiants — Warn patients, especially those with evidence of coronary artery insufficiency, against interruption or d~continuation of nadolol without physician's advice. Although cardiac failure rarely occurs in properly selected patients, edvise patients being treated with beta-adrenergic blocking agents to consult physicien at the first sign or symptom of impending failure. Advise patients of proper course if dose inadvertently missed.

Laboratory Tests — Regularly monitor serum and urine electrolyte levels (see WARNINGS, *Bendroflumethiazide,* and PRECAUTIONS, *General, Bendroflumethiazide).*

Drug Interactions — Nadolol — When administered concurrently the following drugs may interact with beta-adrenergic blocking agents: **Anaesthetics, general** — exaggeration of anesthetic-induced hypotension (see WARNINGS, *Nadolol, Major Surgery).* **Antidiabetic drugs (oral agents and insulin)** — hypoglycemia or hyperglycemia; adjust entidiabetic drug dosege accordingly (see WARNINGS, *Nadolol, Diabetes and Hypoglycemia).* **Catecholamine-depleting druga (e.g., reserpine)** — additive effect; monitor closely for evidence of hypotension and/or excessive bradycardia.

Bendroflumethiazide — When administered concurrently the following drugs may interact with thiazide diuretics: **Alcohol, barbituratas, or narcotics** — mey potentiate orthostetic hypotension. **Antidiabetic druga (oral agents and insulin)** — thiazide-induced hyperglycemia may require adjustment of antidiabetic drug dosage. **Other antihypertansive drugs** — additive or potentiated effect. **Corticosteroids, ACTH** — intensified electrolyte depletion, particularly hypokalemia. **Ganglionic or peripheral adrenergic blocking druga** — potentiated effect. **Preanaathetic and anaathatic aganta** — effects may be potentiated; edjust dosage accordingly. **Preasor aminea (e.g., norapinephrine)** — possible decrease response but not sufficient to preclude their use. **Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarina)** — possible increased response.

Drug/Laboratory Test Interactions — Discontinue thiazides before tests for parathyroid function (see PRECAUTIONS, *General, Bendroflumethiazide).*

Carcinogenesis, Mutegeneals, Impairment of Fertility — Nadolol — In 1 to 2 years oral toxicologic studies in mice, rats, and dogs, nadolol did not produce significant toxic effects. In 2-year oral carcinogenic studies in rats and mice, nadolol did not produce neoplastic, preneoplastic, or nonneoplastic pathologic lesions. **Bendroflumethiazide** — Long term studies in animels have not been performed.

Pregnancy — Teratogenic Effects — Nadolol — Category C. In animal reproduction studies with nadolol, evidence of embryo- and fetotoxicity was found in rabbits, but not in rats or hamsters, at doses 5 to 10 times greater (on a mg/kg basis) than the maximum indicated human dose; no teratogenic potential was seen in any of these species. There are no well-controlled studies in pregnant women; therefore, use nadolol in pregnant women only if potential benefit justifies potential risk to the fetus. **Bendroflumethiazide** — Category C. Animal reproduction studies have not been conducted. This drug's effect on the fetus when administered to a pregnant woman or its effect on reproductive capacity is not known. Bendroflumethiazide should be given to a pregnent woman only if clearly needed. **Nonteratogenic Effects** — Since thiazides cross the placental barrier and appear in cord blood, weigh anticipated benefit of the drug in pregnant women against possible hazards to the fetus; these hezards include fetal or neonatal jaundice, thrombocytopenia, and possibly other reactions which have occurred in adults.

Nursing Mothers — Both nadolol and bendroflumethiazide are excreted in human milk. Because of the potential for serious adverse reactions in nursing infants either discontinue nursing or discontinue therapy, taking into eccount the importance of CORZIDE (Nadolol-Bendroflumethiazide Tablets) to the mother.

Pediatric Use — Sefety and effectiveness in children have not been established.

ADVERSE REACTIONS: Nadolol — Most adverse effects have been mild and transient and have rarely required nadolol withdrawal. **Cardiovascular** — Bradycardia with heart rates of less than 60 beats per minute occurs commonly, and heart rates below 40 beats per minute and/or symptomatic bradycardia were seen in ebout 2 of 100 patients. Symptoms of peripheral vascular insufficiency, usually of the Raynaud type, have occurred in approximately 2 of 100 patients. Cardiac failure, hypotension, and rhythm/conduction disturbances have eech occurred in about 1 of 100 patients. Single instances of first degree and third degree heart block have been reported; intensification of AV block is a known effect of beta-blockers (see also CONTRAINDICATIONS, WARNINGS, and PRECAUTIONS). **Central Narvous System** — Dizziness or fetigue reported in approximately 2 of 100 patients; paresthesias, sedation, and change in behavior reported in approximately 6 of 1000 patients. **Respiratory** — Bronchospasm reported in approximately 1 of 1000 patients (see CONTRAINDICATIONS and WARNINGS). **Gastrointestinal** — Nausea, diarrhea, abdominal discomfort, constipation, vomiting, indigestion, anorexia, bloating, and flatulence each reported in 1 to 5 of 1000 patients. **Miscellaneous** — Each of the following reported in 1 to 5 of 1000 patients: rash; pruritus; headache; dry mouth, eyes, or skin; impotence or decreased libido; facial swelling; weight gain; slurred speech; cough; nasal stuffiness; sweating; tinnitus; blurred vision. Although relationship to drug usage is not clear, sleep disturbances have been reported. The oculomucocutaneous syndrome associated with practolol has not been reported with nadolol. The following adverse reactions may also occur: **Central Nervous System** — reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability with slightly clouded sensorium, decreased performance on neuropsychometrics. **Gastrointestinal** — mesenteric arterial thrombosis; ischemic colitis. **Hematologic** — agranulocytosis; thrombocytopenic or nonthrombocytopenic purpura. **Allergic** — fever combined with aching and sore throat; laryngospasm; respiratory distress. **Miscellaneous** — reversible alopecia; Peyronie's disease; erythematous rash; arterial insufficiency.

Bendroflumethiazide — Gastrointeatinal Syetem — anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis. **Centrel Nervous System** — dizziness, vertigo, paresthesia, headache, xanthopsia. **Hemetologic** — leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia. **Dermetologic-Hypersensitivity** — purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis, cutaneous vasculitis). **Cardiovescular** — orthostatic hypotension may occur. **Other** — hyperglycemia, glycosuria, occasional metabolic acidosis in diabetics, hyperuricemia, allergic glomerulonephritis, muscle spasm, weakness, restlessness. Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

OVERDOSAGE: Nadolol may cause excessive bradycardia, cardiac failure, hypotension, or bronchospasm if overdosed. Overdosage of thiazides may cause lethargy, which may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function and without evidence of serum electrolyte changes or dehydration. Gastrointestinal irritation and hypermotility may occur. Transitory increase in BUN and serum electrolyte changes may occur, especially in patients with renal impairment.

Treetment — Nadolol can be removed from the general circulation by hemodialysis. In determining duration of corrective therapy, take note of the long duration of the effect of nadolol. In addition to gastric lavage, employ the following measures, as appropriate. **Excessive Bredycerdie** — Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **Cerdiec Fellure** — Administer a digitalis glycoside and diuretic. It has been reported that glucagon may also be useful in this situation. **Hypotenaion** — Administer vasopressors, e.g., epinephrine or levarterenol. (There is evidence that epinephrine may be the drug of choice.) **Bronchospasm** — Administer a beta$_2$-stimulating agent and/or a theophylline derivative. **Stupor or Coma** — Supportive therapy as warranted. **Geatrointastinal Effecte** — Symptomatic treatment as needed. **BUN and/or Serum Electrolyte Abnormelities** — Institute supportive measures as required to maintain hydration, electrolyte balance, respiration, and cardiovascular and renal function.

DOSAGE AND ADMINISTRATION: DOSAGE MUST BE INDIVIDUALIZED. Patients with renal failure require adjustment in dosing interval; see package insert for dosage in these patients.

Consult peckege inaert betore prescribing CORZIDE (Nedolol-Bendroflumethiazide Tablets).

HOW SUPPLIED: Available as scored tablets containing 40 mg nadolol combined with 5 mg bendroflumethiazide and 80 mg nadolol combined with 5 mg bendroflumethiazide in bottles of 100.

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COVER

This month's cover of *The Journal* is an illustration of the lead article entitled "Fatal nonmetastatic neurological complications of pulmonary carcinoma." The artist is Richard Remington, medical illustrator at the Learning Resource Center, University of South Florida College of Medicine, Tampa.

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**Includes tuition, printed materials, self-assessment questionnaires, use of audiovisual aids, library loan of TV tapes, cassette tapes and set of slides.*

Another call for unity



This year has passed so quickly that I can hardly realize this will be my last President's Page in *The Journal of the Florida Medical Association, Inc.*

This has been an exciting and turbulent year with some successes and failures.

It has given me an opportunity to get to know many of you and to understand your concerns, your frustrations, and your problems.

I want to express to each of you my deep appreciation of your understanding, your participation and your support, as we addressed the many problems facing us as physicians.

As Jeff Goldsmith, the well-known health care consultant recently stated: "The U.S. health care system is in the throes of a revolution. Power so carefully accumulated for almost five decades is shifting from those who provide care to those who pay for it."

When I was installed as your President a year ago, I called for unity, using the theme: One Profession — One Association — One Future. This theme was selected because it was apparent then that the changes resulting from this transfer of power would be extensive and far-reaching. I must say, however, that I did not anticipate the rapidity with which the changes would occur.

Recently, I heard a speaker state the following: "In times of rapid change and the inevitable troubles that follow, people either come together for mutual protection and comfort, or they pull apart and go off in all directions. This latter course is usually the road to disaster."

Unity among physicians in Florida must continue to be one of our major goals. Toward that end, I have tried this year to improve communication between the FMA leadership and its members with presidential memoranda regarding all important issues, attendance at many county and specialty society meetings, invitations to the Presidents and Executives of County Medical Societies to attend and participate in meetings of the Board of Governors, and voluminous correspondence with many of you.

We have also activated some new committees, such as the Committee on Programs and Priorities to help in long-range planning, and the Committee on Health Manpower to deal with issues involving allied health professions. Our Council on Hospital Medical Staffs is now active and functioning well. Also, the first Seminar for Women Physicians was held in conjunction with our 1985 Leadership Conference.

Detailed studies have been made of the legislative arm of the FMA and of our relationships with the media and other organizations. Some significant changes in direction have resulted from these studies and we hope that we will have more allies in the future.

My sincere thanks go to the Board of Governors, all Council and Committee Members, and to every member of our competent and loyal staff. They all participated in our activities far beyond what would normally be expected of them.

Special thanks go to Don Jones for outstanding performance as our Executive Director, and to my very efficient and dedicated secretary, Liz Parker. Without them, very little would have been accomplished this year.

Frank C. Coleman MD

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EDITORIAL

On parting

Metaphorically speaking, this editorial signals the end of my five year *affair* with an alluring albeit demanding mistress known as *The Journal of the Florida Medical Association*. Having given much of myself in both thought and deed, I am quite naturally saddened by an imposed separation over which neither I nor the *JFMA* has any control. When reminiscing, I shall never forget my early courtship of the *JFMA*. Despite the fact that my initial advances were unsure and perhaps a little awkward, I was determined to win her (*JFMA*) over. Thus, after what seemed like an interminable period of concentrated attentiveness, I finally came to know her true nature and needs. For the two of us, there followed a veritable moment in Camelot. Although it is difficult to describe such happenings, I would characterize my *affair* from a personal standpoint as *one of the most interesting, challenging and intellectually rewarding experiences that I have been privileged to enjoy*. On parting, I trust that I have fulfilled at least some of the hopes and expectations of the *JFMA*.

The operation of a Journal involves numerous, complex, coordinated and time-consuming activities on the part of many individuals. In recognition of the outstanding support afforded me as Editor, I wish to document for *JFMA* archives the following remarks I made in 1983 when accepting the Sandoz Award: *The Award (for the best State Medical Journal) is a reflection of not only a tremendous commitment by the FMA to produce a top quality Journal, but also the dedicated efforts of a collaborative and widely talented Editorial Board and Staff. Moreover, it is only fitting that I pay tribute to my editorial predecessors on whose accomplishments we were able to build. Certainly, any Editor realizes that a Journal will never be better than the papers received and processed by the Advisory Board; hence, I wish to express my sincere appreciation to Contributing Authors and the members of the Consulting Editorial Staff.*

As I bid adieu to the *JFMA*, I want to thank FMA Presidents T. Byron Thames, M.D., Sanford A. Mullen, M.D., Robert E. Windom, M.D., J. Lee Dockery, M.D., and Frank C. Coleman, M.D., for the distinct honor and privilege of serving as Editor. I am especially indebted to Byron Thames who had the courage to give me a start. Finally, I wish to acknowledge the members of my splendid family (Gloria, Myra, Daniel and Andrew) without whose patience and understanding I could not have functioned as Editor.

Daniel B. Nunn, M.D.
Editor
The Journal



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References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
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Increases exercise tolerance*
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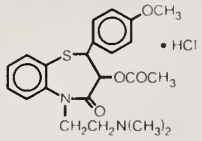
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DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy**—CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

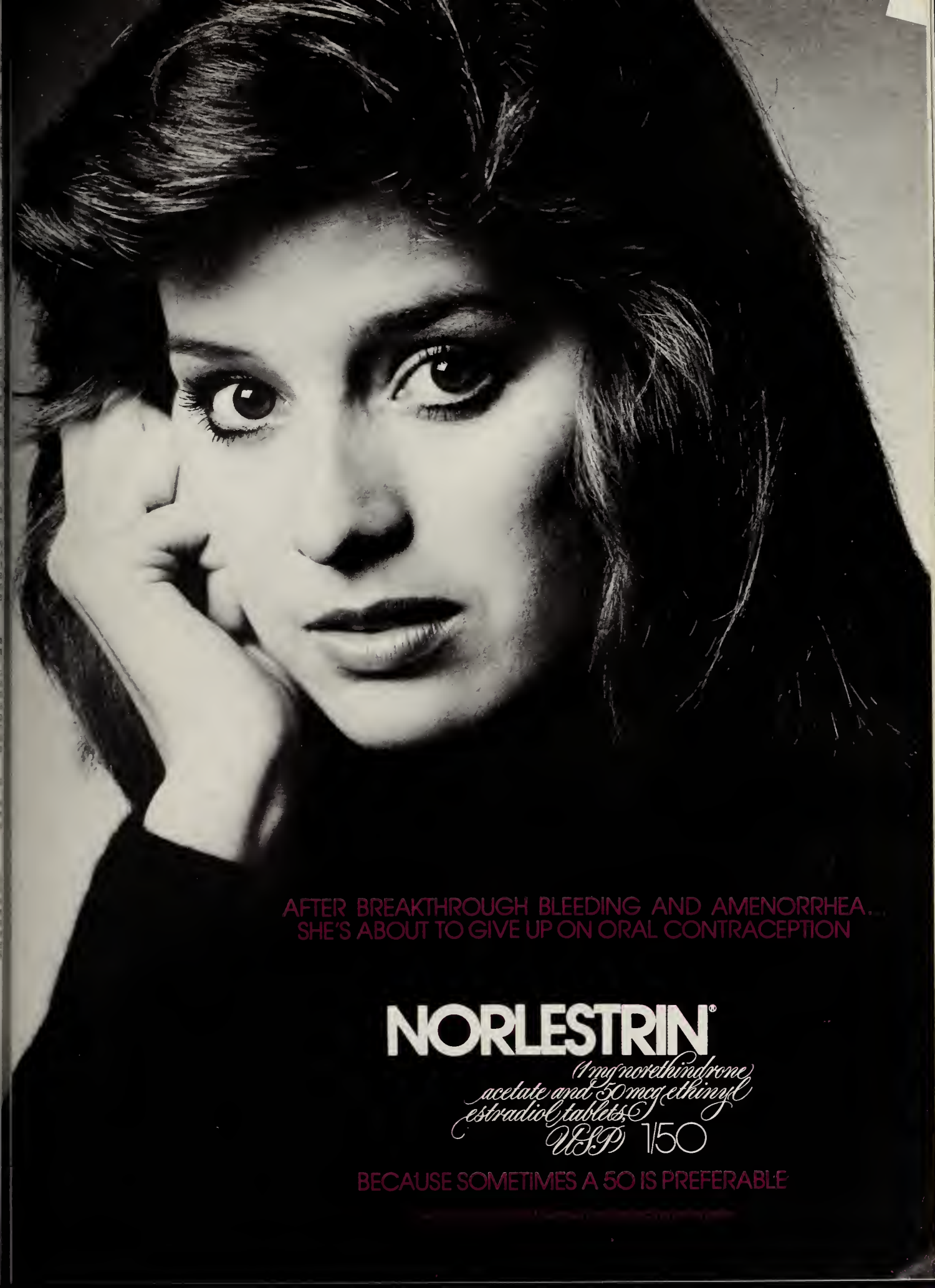
HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NDC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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Brief Summary of Prescribing Information
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Norlestrin Products are progestogen-estrogen combinations.

INDICATIONS AND USAGE
Norlestrin Products are indicated for the prevention of pregnancy in women who elect to use oral contraceptives as a method of contraception.

In clinical trials with Norlestrin 1/50 involving 25,983 therapy cycles, there was a pregnancy rate of 0.05 per 100 woman-years; in clinical trials with Norlestrin 2.5/50 involving 96,388 cycles, there was a pregnancy rate of 0.22 per 100 woman-years.

Dose-Related Risk of Thromboembolism from Oral Contraceptives: Studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. It is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance.

CONTRAINDICATIONS
1. Thrombophlebitis or thromboembolic disorders
2. A past history of deep-vein thrombophlebitis or thromboembolic disorders
3. Cerebral vascular or coronary artery disease
4. Known or suspected carcinoma of the breast
5. Known or suspected estrogen-dependent neoplasia
6. Undiagnosed abnormal genital bleeding
7. Known or suspected pregnancy (See WARNING No. 5)
8. Benign or malignant liver tumor which developed during the use of oral contraceptives or other estrogen-containing products.

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. The risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. *Thromboembolic Disorders and Other Vascular Problems.* An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well-established. Studies have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic.

Cerebrovascular Disorders: In a collaborative study in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than nonusers, and the risk of thrombotic stroke was 4.0 to 9.5 times greater.

Myocardial Infarction: An increased risk of myocardial infarction associated with oral contraceptives has been reported confirming a previously suspected association. These studies found that the greater the number of underlying risk factors (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia) for coronary artery disease, the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor.

It has been estimated that users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are smokers have about a fivefold increased risk of fatal infarction compared to users who do not smoke but about a tenfold to twelvefold increased risk compared to nonusers who do not smoke. The amount of smoking is also an important factor.

Risk of Dose: In an analysis of data, British investigators concluded that the risk of thromboembolism, including coronary thrombosis, is directly related to the dose of estrogen used in oral contraceptives; however, the quantity of estrogen may not be the sole factor involved.

Persistence of Risk: Two studies have suggested that an increased risk may persist for as long as 6 years after discontinuation of oral contraceptive use for cerebrovascular disease and 9 years for myocardial infarction. In addition, a prospective study suggested the persistence of risk for subarachnoid hemorrhage.

Estimate of Excess Mortality from Circulatory Diseases: The risk of diseases of the circulatory system is concentrated in older women, in those with a long duration of use, and in cigarette smokers.

A study of available data from a variety of sources concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke.

The risk of thromboembolic and thrombotic diseases associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia, and especially by cigarette smoking.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders. Should any occur or be suspected, the drug should be discontinued immediately.

A fourfold to sixfold increased risk of postsurgery thromboembolic complications has been reported in users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization.

2. *Ocular Lesions.* Neuro-ocular lesions, such as optic neuritis or retinal thrombosis, have been associated with the use of oral contraceptives. Discontinue the oral contraceptive if there is unexplained sudden or gradual, partial, or complete loss of vision; onset of proptosis or diplopia; papilledema, or retinal vascular lesions.

3. *Carcinoma.* Long-term continuous administration of estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver.

In humans, an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women has been reported. However, there is no evidence suggesting increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives.

Studies found no evidence of increase in breast cancer in women taking oral contraceptives, however, an excess risk in users with documented benign breast disease was reported.

There is no confirmed evidence of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of users is, nevertheless, essential. In cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer, or who have breast nodules, fibrocystic disease, or abnormal mammograms, should be monitored with particular care.

4. *Hepatic Tumors.* Benign hepatic adenomas have been found to be associated with oral contraceptives. Because hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage, they should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time.

5. *Usage in or Immediately Preceding Pregnancy, Birth Defects in Offspring, and Malignancy in Female Offspring.* During early pregnancy, female sex hormones may seriously damage the offspring.

An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of oral contraceptives in pregnancy.

There is some evidence that triploidy and possible other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives.

Pregnancy should be ruled out before continuing an oral contraceptive in any patient who has missed two consecutive menstrual periods. If the patient has not adhered to the schedule, the possibility of pregnancy should be considered at the time of the first missed period, and oral contraceptives should be withheld until pregnancy has been ruled out. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed.

Women who discontinue oral contraceptives with the intent of becoming pregnant should use an alternate form of contraception for a period of time before attempting to conceive.

Administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. *Gallbladder Disease.* Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives.

7. *Carbohydrate and Lipid Metabolic Effects.* Because decreased glucose tolerance has been observed in a significant percentage of patients, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed.

8. *Elevated Blood Pressure.* An increase in blood pressure has been reported in patients receiving oral contraceptives. The prevalence in users increases with longer exposure. Age is also strongly correlated with development of hypertension. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure.

9. *Headache.* Onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives.

10. *Bleeding Irregularities.* Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, nonfunctional causes should be borne in mind. In undiagnosed abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy.

Women with a past history of oligomenorrhea or secondary amenorrhea, or young women without regular cycles should be advised that they may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives.

11. *Ectopic Pregnancy.* Ectopic as well as intrauterine pregnancy may occur in contraceptive failures.

12. *Breast-Feeding.* Oral contraceptives may interfere with lactation. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs.

PRECAUTIONS
1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another examination.
2. Preexisting uterine leiomyomata may increase in size.
3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree.
4. Oral contraceptives may cause fluid retention and should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated.
5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice. If jaundice develops, the medication should be discontinued.
6. Steroid hormones may be poorly metabolized and should be administered with caution in patients with impaired liver function.
7. Users may have disturbances in normal tryptophan metabolism, which may result in a relative pyridoxine deficiency.
8. Serum folate levels may be depressed.
9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted.
10. Certain endocrine and liver function tests and blood components may be affected: (a) Increased sulfobromophthalein retention. (b) Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. (c) Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone. (d) Decreased pregnanediol excretion. (e) Reduced response to metyrapone test.

Drug Interactions: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, tetracycline, and ampicillin.

ADVERSE REACTIONS
An increased risk of the following serious adverse reactions has been associated with oral contraceptives: thrombophlebitis; pulmonary embolism; coronary thrombosis; cerebral thrombosis; cerebral hemorrhage; hypertension; gallbladder disease; benign hepatomas; congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: mesenteric thrombosis; neuro-ocular lesions, eg, retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related: nausea and/or vomiting, usually the most common adverse reactions, occur in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally: gastrointestinal symptoms; breakthrough bleeding; spotting; change in menstrual flow; dysmenorrhea; amenorrhea during and after treatment; temporary infertility after discontinuance of treatment; edema; chloasma or melasma; breast changes; change in weight; change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum; cholestatic jaundice; migraine; increase in size of uterine leiomyomata; rash (allergic); mental depression; reduced tolerance to carbohydrates; vaginal candidiasis; change in corneal curvature; intolerance to contact lenses.

The following adverse reactions have been reported and the association has been neither confirmed nor refuted: premenstrual-like syndrome; cataracts; changes in libido; chorea; changes in appetite; cystitis-like syndrome; headache; nervousness; dizziness; hirsutism; loss of scalp hair; erythema multiforme; erythema nodosum; hemorrhagic eruption; vaginitis; porphyria.

Special Notes on Administration
Menstruation usually begins two or three days, but may begin as late as the fourth or fifth day after discontinuing medication.

After several months on treatment, bleeding may be reduced to a point of virtual absence; reduced flow may be a result of medication and not indicative of pregnancy.

HOW SUPPLIED
Norlestrin [21] 1/50 is available in compacts each containing 21 tablets. Each tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin [21] 2.5/50 is available in compacts each containing 21 tablets. Each tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin [Fe] 1/50 is available in compacts each containing 21 yellow tablets and 7 brown tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin [FE] 2.5/50 is available in compacts each containing 21 pink tablets and 7 brown tablets. Each pink tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate, USP. Available in packages of five compacts and packages of five refills.

Norlestrin [28] 1/50 is available in compacts each containing 21 yellow tablets and 7 white inert tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

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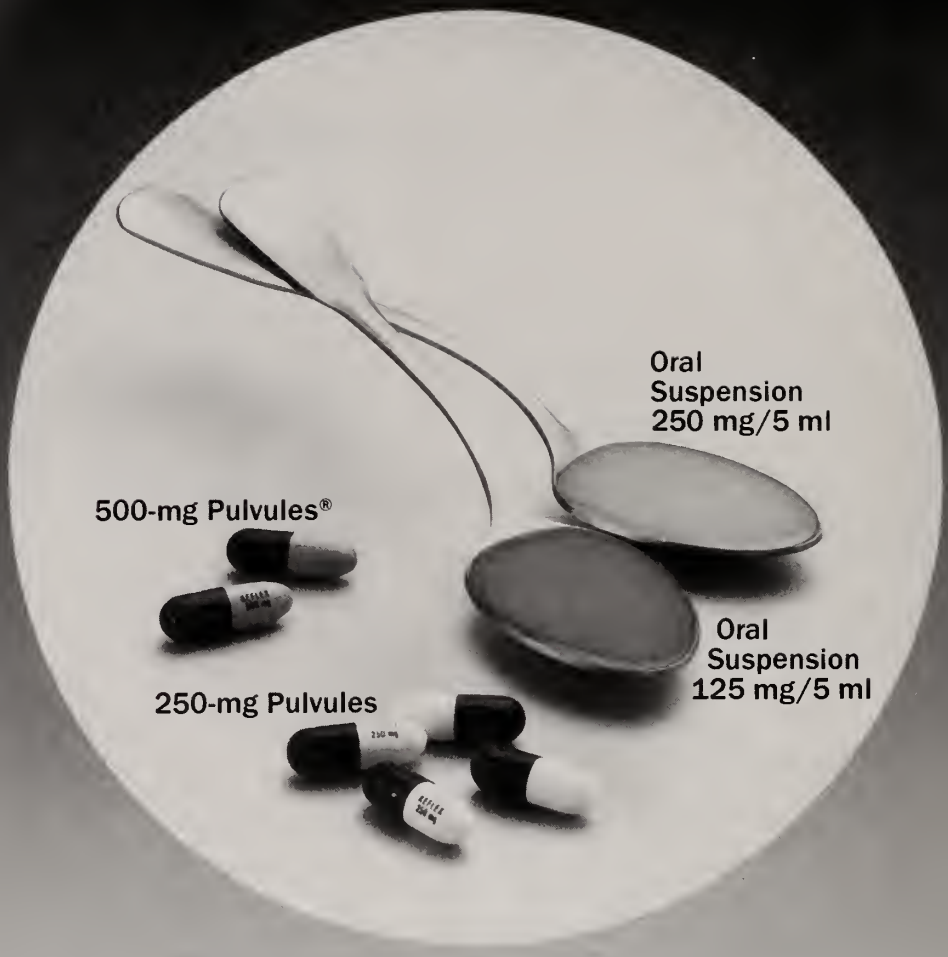


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Fatal nonmetastatic neurological complications of pulmonary carcinoma

Leon D. Prockop, M.D. and Stephen L. Buchdolt, M.D.

ABSTRACT: Although the nervous system (NS) complications of metastatic carcinoma are common and well known, the less common nonmetastatic or remote effects also cause morbidity and mortality. We report a 60-year-old man in whom peripheral numbness developed and then progressed to polyneuropathy, dementia, seizures, myoclonus, and death within six months. Postmortem examination disclosed a retrohilar small cell (oat cell) lung carcinoma with only limited local spread and NS microscopic findings consistent with remote effects of carcinoma.

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The nervous system complications of metastatic systemic carcinoma are common, well-known and devastating. For example, 5-10% of all patients with melanoma will develop brain metastases. As a further example, survival after diagnosis of metastatic brain melanoma is limited, eg, 3-4 months varying with reported series. Similar and sometimes less pessimistic figures pertain to other forms of systemic carcinoma. The nervous system nonmetastatic complications (remote effects) of systemic cancer are much less common but also provide serious threat to the afflicted individual's duration and quality of life.

A 60-year-old man with onset of subacute disease in July 1981 starting with peripheral numbness and progressing to polyneuropathy, dementia, seizures, and myoclonus expired in January 1982. Postmortem examination disclosed a retrohilar small cell (oat cell) undifferentiated lung carcinoma with only local paratracheal metastases. There were no nervous system tumor cells but microscopic findings were consistent with the remote effects of carcinoma.

Case report — In July 1981 a previously healthy 60-year-old man noted numbness in the hands. This progressed and diffuse weakness ensued such that he could not walk unassisted one month later. A ten pound weight loss occurred. General physical examination in an alert man without familial or individual risk factors for disease except a 40 pack/year history of cigarette smoking was unremarkable. Neurological examination demonstrated mild dementia characterized by recent memory impairment with decreased factual fund in the context of his previous education and occupation, diffuse mild weakness with hyporeflexia and a glove and stocking distribution of decreased perception of touch, vibration, pin and temperature sensations. On admission to hospital, the results of a CBC and urinalysis, SMA-16, and urine heavy metal screen were

normal, as was chest x-ray and EKG. Electromyogram showed denervation potentials. Nerve conduction velocities showed slowing consistent with peripheral neuropathy, nonspecific. No etiology was apparent. After discharge, a left-sided focal seizure occurred which subsequently became generalized. On hospital readmission the chronically ill appearing man demonstrated no specific abnormalities on general physical examination except those consistent with a history of weight loss, now 40 pounds. Neurological examination described more severe dementia, moderate generalized weakness and wasting, arreflexia, and sensory impairment more profound than before. He exhibited spontaneous and almost continuous myoclonic jerks, which disappeared with sleep and when they were obscured by frequent generalized tonic-clonic seizures. Blood and urine studies were as previously perfomed; now including thyroid screen studies. Carcinoma embryonic antigens level was 3.1 ng/ml. An EEG was markedly abnormal with generalized slowing and disorganization consistent with diffuse encephalopathy with evidence of right frontal sharp activity of an epileptiform nature. Brain CT findings were consistent with mild cortical atrophy most prominent frontally. X-rays of the lumbar spine and feet were normal as was an intravenous pyelogram. Chest x-ray was unremarkable except for left hilar prominence. The patient continued to deteriorate and became semicomatose in December, suffering continuous myoclonic jerks and frequent generalized seizures. The seizures were refractory to a variety of anticonvulsive medications including phenytoin, carbamazepine, valproic acid, phenobarbital, and primidone. The myoclonic jerks were refractory to a variety of other medications, including haldoperidol, levodopa,



Fig. 1 — A five cemtimeter, tan, partially necrotic mass was found attached to the external surface of the trachea at the bifurcation.

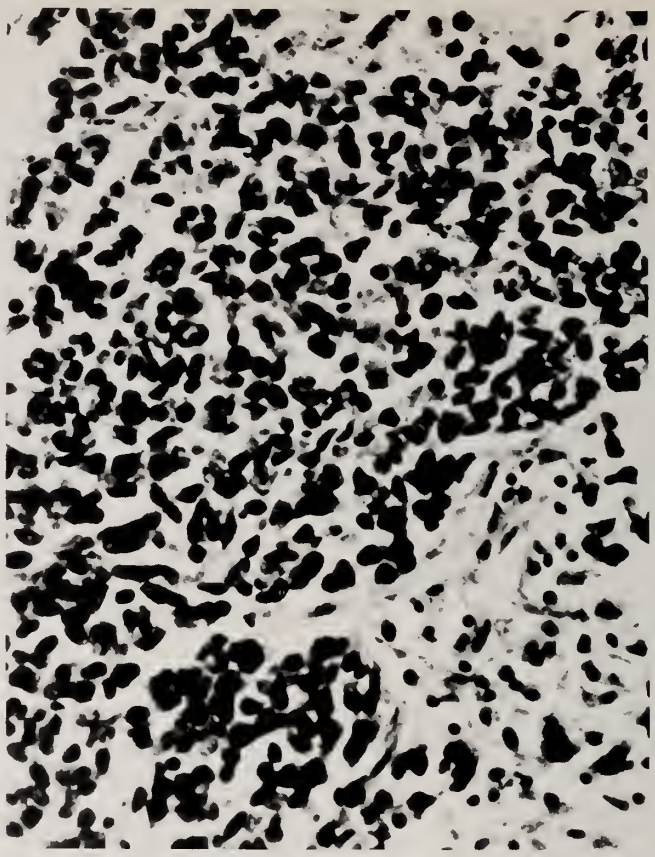


Fig. 2 — The mass was composed of small hyperchromatic round to spindle-shaped cells with the characteristic molding of small cell carcinoma. (H & E, x400).

diazepam, and phenothiazine derivatives. Further laboratory evaluation directed toward disclosing an etiology, including that of systemic carcinoma, was again normal, now including upper and lower GI series and analysis of cerebral spinal fluid obtained at lumbar puncture. Chest x-rays again demonstrated its left hilar prominence unchanged. Several EEG studies showed progressive deterioration with absence of normal wave forms and generalized slowing with intermittent spike and slow wave discharge as well as prominent hysarrhythmic wave forms. Despite supportive measures including pulmonary toilet, bowel and bladder care, nasogastrioc feedings, and physical therapy, the patient expired in January 1982, seven months after onset of illness.

At postmortem examination systemic findings included: muscular wasting, bronchopneumonia, and organizing broncheolitis, aortic saccular aneurysm, and congestion of the liver, spleen and kidney. A well-circumscribed partially necrotic mass was found attached to the external trachium at the bifurcation (Fig. 1). A 1 cm firm well-circumscribed mass was found in the left lung parenchyma near the hilum. Both masses on microscopic examination were composed of small, hyperchromatic, round to spindle-shaped cells arranged randomly and with characteristic molding and morphology of small cell (oat cell) carcinoma (Fig. 2). The left intraparenchymal mass was interpreted to be the primary. Other than the tracheal mass, no metastatic lesions were found elsewhere, including the nervous system. Grossly, the brain was normal. Microscopic brain cortical vessels were found cuffed by lymphocytes (Fig. 3). Except for slight loss in the hippocampus, neurons were normal. There was patchy decrease of cellular Pukinji cells. The spinal cord

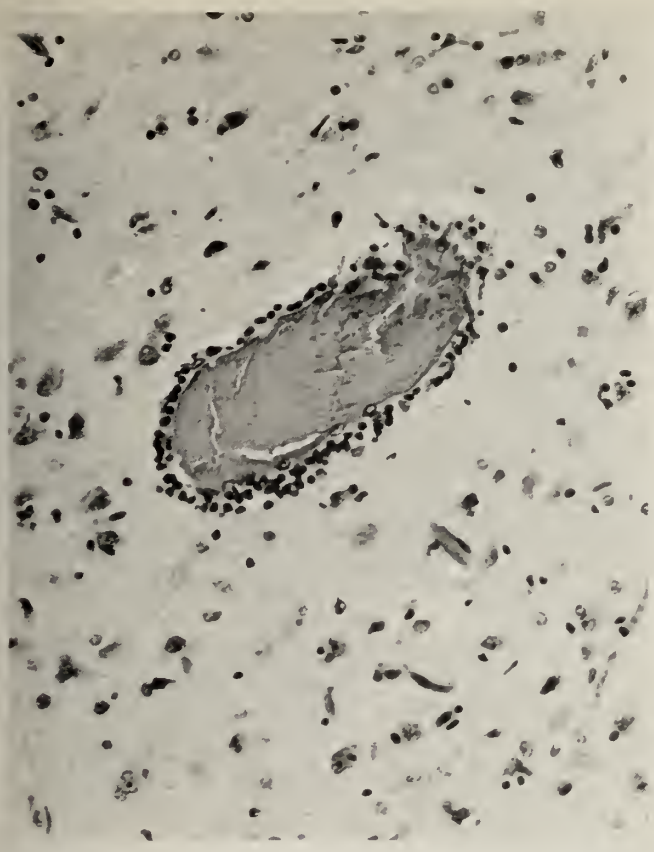


Fig. 3 — Microscopic examination of the brain showed perivascular cuffing of cortical vessels by lymphocytes. The surrounding neurons appeared normal. (H & E, x400).



Fig. 4 — Microscopic examination of the posterior columns of the spinal cord showed severe vacuolar degeneration. (H & E, x400).

grossly showed the posterior columns to be whiter and more glistening than normal. Microscopically, the posterior columns showed severe vacuolar degeneration (Fig.4).

Discussion • This patient presented with symptoms and signs of peripheral neuropathy which persisted until his death. Extensive evaluation demonstrated no etiology. Subsequently he exhibited signs and symptoms of central nervous system disease including dementia, seizures and myoclonal jerks as well as coma. Further extensive evaluation of potential etiologies was unrewarding; therefore, two diagnoses came under primary consideration: a remote effect of carcinoma, and Creutzfeldt-Jakob disease (CJ disease).

CJ disease is characterized by dementia associated with various neurological manifestations including lower motor neurodysfunction, seizures, and myoclonic jerks. The disease is rapidly progressive and usually fatal within months after onset, the EEGs characterized by hyparrhythmia as seen in this patient. Such findings are often considered "pathognomonic of CJ disease." However, the diagnosis

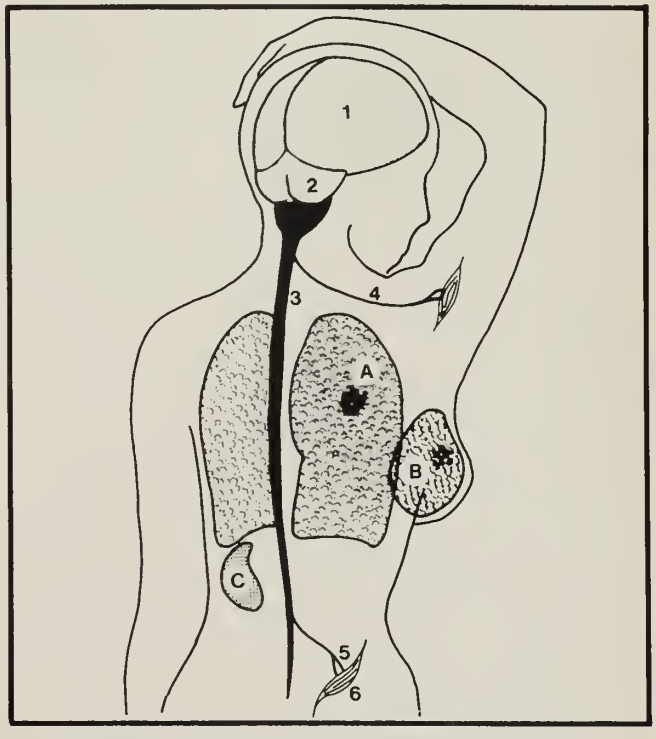


Fig. 5 — Diagramatic illustration of the nonmetastatic complications of systemic neoplasia. For examples, neoplasia of lung (A), breast (B), or lymphoid tissues (C) may affect: Cerebrum (1), cerebellum (2), spinal cord (3), peripheral nerve (4), myo-neural junction (5) or muscle (6). See Table 1.

Table 1. — Paraneoplastic Syndromes of Brain, Nerve, and Muscle.

Disease	Associated Tumors	Number With Tumors
Encephalomyelitis	Oat cell, lymphoma	Unknown
Opsoclonus-myoclonus	Neuroblastoma	50%
Cerebellar degeneration	Oat cell	Unknown
Dysautonomia	Oat cell	80%
Polyneuritis	Lymphoma	Most
Sensory Neuropathy	Oat cell	5%
Myasthenia	Thymoma; breast	Most
Lambert-Eaton syndrome	Oat cell	30%
Polymyositis	Breast; lung, ovary	Most

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cannot be made with certainty without postmortem examination. In CJ disease, neuronal cell depopulation with spongiosis and dense astrocytic gliosis of the cerebral cortex is noted, findings not present in this patient.

The postmortem findings of small cell carcinoma and absence of metastatic disease led to the diagnosis of a nonmetastatic complication of carcinoma. The microscopic findings, particularly perivascular lymphocytic cuffing in the cortex, cerebellar Purkinje cell dropout, and spinal cord posterior column degeneration are consistent with, but not specific to, this disorder.

Peripheral neuropathy and myopathy in patients with lung carcinoma was described by Denny-Brown in 1948.[1] In 1951 Brain, Daniel and Greenfield described the relationship of subacute cortical cerebellar degeneration and carcinoma.[2] These neuromuscular disorders were not due to metastatic disease. Charatan and Brierley reported the association of mental disorder with lung carcinoma in 1956[3] and in 1958 Astrom, Mancall and Richardson described a new demyelating syndrome (multifocal leukoencephalopathy) associated with malignant lymphoid tissue neoplasia.[4] The relationship between dermatomyositis and malignant tumors was defined by Dostrovsky and Sagher in 1946.[5] Subsequently it has been increasingly recognized that neuromuscular disorders may be the presenting and dominating clinical aspect of patients with tumor without nervous system metastases.[6-10] The paraneoplastic syndromes of brain, nerve and muscle are summarized in Table 1. Spectrum of nonmetastatic complication of malignancy are diagramatically illustrated in Figure 5.

Although the pathogenesis of the syndromes is not understood, an immunological one may be present.[11-14] Evidence for this hypothesis includes documentation of antibodies to cerebellar Purkinje cells in patients with paraneoplastic cerebellar degeneration and ovarian carcinoma[12] and sural nerve immune deposits in polyneuropathy as a remote effect of carcinoma.[13]

In the case reported here, pulmonary carcinoma was not recognized during life. In retrospect the prominence of hilar structures as noted by x-ray could have prompted further investigation, eg, CT of the chest. Although the tumor's location may have prevented surgical removal, radiation therapy and chemotherapy may have provided amelioration and perhaps some reversal of the neurological syndrome. In this circumstance, there was an unusual coexistence of several nervous system nonmetastatic complications of carcinoma, ie, involvement of the cerebrum, cerebellum, spinal cord, and peripheral nerves.

Clinical awareness of the paraneoplastic complications of systemic carcinoma is important because no definitive diagnostic laboratory data may be available and treatment of the primary disease may ameliorate the nervous system complications, thereby improving the patient's quality of life.

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Children's Medical Services: Florida's expanded Crippled Children's Program from the 1920s to the 1980s

Martin L. Schulkind, M.D. and W. W. Ausbon, M.D.

ABSTRACT: In 1982, more than 56,000 of Florida's children and adolescents were provided with medical services under the sponsorship of the State of Florida's Department of Health and Rehabilitative Services Children's Medical Services Program. From its humble beginnings in 1929 as a program for children with primarily orthopedic problems, it has expanded to a 66.5 million dollar program serving children with all medical conditions which interfere with their normal growth and development. This paper describers the efforts of the many physicians and lay persons who helped to develop what some have called the model program in the United States for the care of children with chronic diseases.

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In his 1980 monograph "The Crippled Children's Services," Henry Ireys said, "In most every state, the Crippled Children's Services program is struggling; economic realities are forcing programs to curtail services; competition in the state political hierarchy is fierce; medical care costs continue to rise rapidly; and old alliances hobble innovations."[1]

Florida's crippled children's program, Children's Medical Services, is an exception. Although economic cutbacks have forced many programs to curtail services in Florida, Children's Medical Services (CMS) has continued to get increased funding despite decreasing federal support of such programs. State legislative support has actually continued to rise over the years.

Why is Florida's experience so different from the rest of the programs in the country? Ireys[1] states that a crippled children's agency must have a good administrative location in the state government in order to achieve program visibility to the governor and the legislature.

This line of reasoning motivated several Florida physicians concerned about the welfare of chronically ill children to seek a political solution to this problem. These physicians, mostly through the efforts of the Florida Pediatric Society and Florida Chapter of the American Academy of Pediatrics, realized that they had some legislative voice after successfully lobbying for a neonatal insurance bill that passed in 1971. They then launched a campaign to raise the Bureau of Crippled Children's administrative status to a Division of Children's Medical Services. Legislation failed passage the first time around but did get passed in the 1973 session.

Division of Children's Medical Services • In 1973, when the legislature amended the Florida Statutes to establish two new divisions within the Department of Health and Rehabilitative Services (HRS), the Division of Children's Medical Services (CMS) and Division of Aging and Adult Services were created. As a result, the Bureau of Crippled Children underwent a name change and was elevated from Bureau status within the Division of Vocational Rehabilitation to an administrative status equivalent to that of other divisions in HRS.

This gave the crippled children's program more visibility when the legislature deliberated on its budget. With increased visibility came increased funding and expansion of the program for indigent, chronically ill children. For example, between 1972 and 1982, the budget rose from $7.72 million, serving 22,000 patients, to $61.49 million, serving 45,000 patients. Strong governmental liaison with members of the Florida Pediatric Society and other physicians has resulted in one of the best state-supported health programs for chronically ill children and youth in the United States.

The early years: Florida Crippled Children's Commission • The earliest efforts to create a statewide program for crippled children in Florida were made in 1906 when a law was enacted to establish a centralized program that would provide medical care. It failed to materialize. In 1911, another attempt was made. The law was changed to establish a decentralized program to be administered by the State Board of Health, but a sharp cut in appropriations in 1921 curtailed the Board's activities. Again the special program for crippled children fell by the wayside.

By 1928 interest in the welfare of crippled children had grown. A statewide survey determined how many crippled children resided in Florida and what their needs were. Members of the Florida American Legion organized and conducted the survey assisted by the Rotary and Kiwanis clubs, women's clubs, and other organizations. The survey reported 700 crippled and 309 blind children. In response to this survey, the 1929 legislature enacted the law establishing the Florida Crippled Children's Commission (FCCC).

The FCCC program, established by Statute 391, was decentralized, providing services previously offered by the State Board of Health. It had five members appointed by Governor Doyle E. Carlton and charged with ensuring that "every indigent or partially indigent child in Florida might have promptly and efficiently the best surgical and medical care available in the State." The legislative act gave the commission power to designate hospitals, clinics, and other medical centers as service providers. It would pay the medical expenses of eligible children, and employ physicians, nurses, and other professional staff.

Florida Statute 391 defined a crippled child as any person of normal mentality under age 17 whose physical functions or movements have been impaired by accident, disease, or congenital deformity. Indigency was to be determined and certified by the juvenile courts or the county judges.

Three orthopedic surgeons provided medical leadership and supervised care delivery to the children in three districts: F.L. Fort, M.D., North Florida; Prescott Le Breton, M.D., Central Florida, and A.H. Weiland, M.D., South Florida. The State Board of Health and the FCCC established a cooperative program in which the Board provided office space and clerical assistance for the surgeons and the FCCC transferred funds to the Board for matching purposes.

In 1930 the FCCC began to establish clinics and enter into contracts with hospitals. By 1931 medical centers were designated throughout the state, guided by recommendations of the American College of Surgeons, American Hospital Association, and State Board of Health.

Initially the FCCC program was concerned solely with orthopedic problems. Poliomyelitis victims were the first main source of patient supply and all services were provided by orthopedic surgeons. In 1931, the first year of operation, 937 patients received medical services. The biennial appropriation for 1931-1932 was $50,000.

Title V of the Social Security Act • In 1935 the U.S. government enacted Title V of the Social Security Act adding federal financial support to the FCCC program. This enabled the Commission to extend its program to children with cleft lip and cleft palate deformities. These children required the expertise of plastic surgeons and the Commission paid them on a fee-for-service basis.

As the years passed and Florida's population grew, more service districts were established. In 1939, the Commission created five districts, in St. Petersburg, Jacksonville, Pensacola, Orlando, and Miami. Each district was headed by an orthopedic surgeon, orthopedic field nurse, physiotherapist, and a secretary. During World War II, although the shortage of personnel put a strain on all services and staff, the Commission continued providing unabated care to Florida's crippled children.

In 1947 the state legislature redefined crippled child as "any person of a normal mentality under the age of 21 years whose physical function or movements have been impaired by accident, disease, or congenital deformity regardless of whether or not such impaired physical functions or movements are due to a orthopedic condition; it shall include children suffering from any disease or condition which

is likely to result in a crippled condition." At this time federal funding increased allowing expansion of the FCCC program to include children crippled by a variety of conditions besides orthopedic problems.

Postwar years • To allow children to benefit both medically and educationally from state agencies, Florida's Division of Vocational Rehabilitation joined the FCCC in a cooperative agreement in 1947. However, in 1948, despite increasesd demands, the FCCC program had to cut services due to insufficient funds. The Florida Association for Crippled Children and Adults offered to serve as liaison between the FCCC and the community to find some way to provide care to the growing number of children.

In October 1948, the Nemours Foundation, a private nonprofit agency, started a program of direct aid to cirppled children in Florida. It gave invaluable assistance to the FCCC for 12 years, during a period when state and federal funds could not meet all the medical needs of crippled children. In addition the Foundation made it possible for children with certain types of deformities to receive hospital and surgical care at the Alfred I. Dupont Institute in Wilmington, Delaware, at no cost to the Commission.

In the next two to three years, the FCCC made additional cooperative arrangements with private nonprofit agencies to ensure better care for crippled children. In 1951 the Nemours Foundation sponsored a conference taht helped launch a multidisciplinary approach to the care of children with cleft lip and cleft palate. That same year the FCCC drew up an agreement with the National Foundation for Infantile Paralysis whereby it paid for medical services for children with post-polio disabilities while the National Foundation provided braces and other appliances. Unfortunately this agreement ended in 1953. In addition the FCCC established cooperative programs with the United Cerebral Palsy Association to care for children with cerebral palsy in some district medical centers.

In 1953 crippled children's eligibility ceased to be a court function; the FCCC empowered the State Director of Services to make this determination. Also in 1953, the FCCC established a program of services for children with operable heart diseases with the help of the Children's Bureau, Florida Heart Association, and Florida State Board of Health. The FCCC formed a Cardiac Advisory Committee to oversee the heart program and establish its standards and regulations.

To reduce hospital costs and yet provide the best care for greater numbers of children, the FCCC created a foster home program in cooperation with the Children Services Bureau of the Florida Department of Welfare. The program served FCCC-sponsored children who lived far from district centers and whose parents could not care for them at home.

In the late 1950s, the FCCC made cooperative arrangements with the newly opened College of Medicine of the University of Florida and the University of Miami School of Medicine to start centers for children with cardiovascular disorders.

By the early 1960s, 11 service districts had been established with new ones in Tallahassee, Sarasota, West Palm Beach, Gainesville, Lakeland, Tampa, and a subdistrict in Panama City. The rapid growth reflectd increasing needs during a period of sharp rise of the state's population. At this same time the term "normal mentality" was deleted from the definition of a crippled child and the FCCC signed a statement of compliance with the Civil Rights Act of 1964. These actions were a part of the changing perspectives of American society during the 1960s.

Bureau of Crippled Children (BCC) • In 1969, the Florida legislature enacted legislation placing health and rehabilitative agencies within the same department. Thus, health and rehabilitative agencies were placed in the new Department of Health and Rehabilitative Services.

With reorganization the FCCC Policy Board became the Statutory Advisory Council which created a meeting policy whereby the Council met in each of the districts successively. In this way the staff of each district could bring problems for consideration and the Council would stay informed of all the districts' operations. In addition District Medical Advisory Committees were formed to consider local programs, present ideas for solution of problems, and give the local program direction. In 1969 the Bureau served 13,670 patients with a budget of $3.28 million.

In 1970 special referral districts were set up at the University of Florida and University of Miami to handle patients from other districts. The next two years saw BCC services extended to include an ophthalmology program, neonatal program, diabetes camp program, pilot study for leukemia patients, and cystic fibrosis clinics in Orlando, St. Petersburg, Pensacola, and Gainesville. Also, it created policies providing services to BCC-eligible patients who were clients of Division of Vocational Rehabilitation as well as residents of Florida's School for the Deaf and Blind. Shortly thereafter another district was set up at the University of Miami while subdistricts were established at Daytona Beach and Fort Myers.

Division of Children's Medical Services • In 1973 the Florida legislature elevated the Bureau of Crippled Children to the status of the Division of Children's Medical Services. The Statutory Advisory Council continued to advise the Director of the Division.

In 1974 Secretary O.J. Keller in an administrative order prompted by a lawsuit against the state on behalf of children with hemophilia stated that CMS must have a uniform program. It must accept every financially eligible child with a chronic disease regardless of the cost of care but within the fiscal limitations of the Division. In 1974 the Division Director, Gerold L. Schiebler, M.D., suggested that the Division try to begin a grant-in-aid program to underwrite the costs of some neonatal intensive care units (NICUs). These monies would be granted to designated hospitals for one year with the understanding that CMS children would receive services free. Also in 1974 the Florida legislature appropriated funds for CMS to establish five regional Neonatal Intensive Care Centers.

During this periodd of growth and change, Dr. Schiebler took a leave of absence as Chairman of the Department of Pediatrics at the University of Florida to become CMS Director in 1974-1975. He had the support of CMS's District Medical Directors, pediatricians, other physicians and surgeons for children, and the Secretary of HRS. As a result new programs were established and legislative support was garnered. As advocates for children's health programs, they agreed that the early intervention and rehabilitation of children with chronic disorders allow children to return to the mainstream of life; thus preventing development of invalidism and continued dependency. By investing tax dollars in rehabilitating chronically ill children, the state would save money by not being burdened with their care as disabled adults.

Legislation for new program • The legislature was convinced of the validity of these arguments. In 1974 two new programs were established as grants-in-aid, the Regional Neonatal Program and the Statewide Renal Program, both aimed at preventing long-term disability. The neonatal program's objective was preventing developmental disability and neurological impairment. The renal program's goal was preventing end-stage renal disease. These programs and others were established, proved themselves effective, and were recognized and applauded by the public and the legislature.

The 1974 legislature included in its appropriations a grant-in-aid for a statewide renal program. All patients being screened for CMS services were to be screened for chronic or recurrent renal disease. Also two centers were to be developed, one at the University of Miami Medical Center and the other at the University of Florida Health Center.

In 1976 the legislature passed a statute (Section 383.15-21) to get a neonatal program formally on its way. In 1977 this statute was amended to include "high risk" pregant women and to mandate the formation of ten regional centers. Now called the Perinatal Intensive Care Program, the program had centers termed Perinatal Intensive Care Centers. The Florida Perinatal Program goals resembled those of the National Perinatal Task Force: "the intense survival of all infants by means of a regional perinatal intensive care system."

The Division acted as the focus for establishment of the Rheumatic Fever and Rheumatic Heart Disease Task Force. This represented a cooperative effort of HRS, Florida Health Association, and Florida Medical Association to coordinate the Rheumatic Fever and Rheumatic Heart Disease Program and computerize its data for the state.

Rapid expansion of services • In 1975 CMS signed an agreement with the Division of Vocational Rehabilitation (DVR) that shared responsibility for youths 16-21 years old. It also facilitated transfer care of CMS patients with chronic problems to DVR, the agency that provides rehabilitation care for adults with chronic illnesses so that they may become gainfully employed.

Over the next few years the Division and its successor, the CMS Program Office of the reorganized Department of Health and Rehabilitative Services, developed regional programs for children with diabetes and genetic disorders as well as special programs in hematology/oncology, neurology/neurosurgery, spina bifida, complex neonatal surgery, pulmonary disease, speech and hearing problems, spinal cord injuries, and impaired vision (Table 1). The well-established cardiac and orthopedic programs continued. The expansion of these programs resulted from increased funding by the legislature. The 1983 fiscal year budget appropriated $61.49 million for this purpose.

In the decade 1972-1982, the number of children served by CMS doubled (Fig. 1). This same period witnessed a tenfold increase in legislative appropriation for CMS programs, despite plateauing and eventually decreasing federal funding (Fig. 2, Table 2). This increase was high relative to the increase in the state population, which grew from 6.79 million in 1970 to 9.74 million in 1980. It is also interesting to note that while Florida experienced a 43.4% increase in population, this included a major increase (70%) in the number of citizens 65 years and older. One must infer that the strong funding support for CMS programs did not reflect just a rising number of children needing to be served. It was the legislature's response to the quality and quantity of services rendered by CMS to the indigent children of Florida.

Most CMS patients are now seen in multidisciplinary clinics (Table 3). Such arrangements provide them with comprehensive care and give access to the most qualified professional expertise available in each service delivery area. Over the years CMS has

Table 1. — Children's Medical Services Special Patient Programs, Contracted Special Programs, and Miscellaneous Programs.

SPECIAL PATIENT PROGRAMS	CONTRACTED SPECIAL PROGRAMS	MISCELLANEOUS PROGRAMS
Pediatric (general)	Child protection (teams)	General pediatric surgery
Cardiology	Diabetes	Endocrinology
Hematology/oncology	Genetics	Immunology
Neurology/neurosurgery	Infant metabolic screening and hearing screening	Chronic infectious diseases
Newborn spina bifida	Renal	Gastroenterology
Complex neonatal surgery	Rheumatic fever/rheumatic heart disease	Pediatric urology
Orthopedics	Perinatal	Sudden infant death syndrome
Pulmonary disease	Fetal alcohol syndrome	
Speech and hearing	Sickle cell screening	
Vision		

acquired the reputation of giving outstanding health care to indigent, chronically ill children — care equal if not superior to that provided affluent patients.

Administrative structure of CMS • An additional factor in the success of CMS is its unique mode of administration in which the private sector and state government play closely integrated roles. CMS has 18 service delivery offices located in the 11 administrative districts of HRS.

Each service delivery office is administered by a physician Medical Director who is contracted by HRS to supervise a local CMS program. Each HRS district also has a CMS Program Supervisor who is

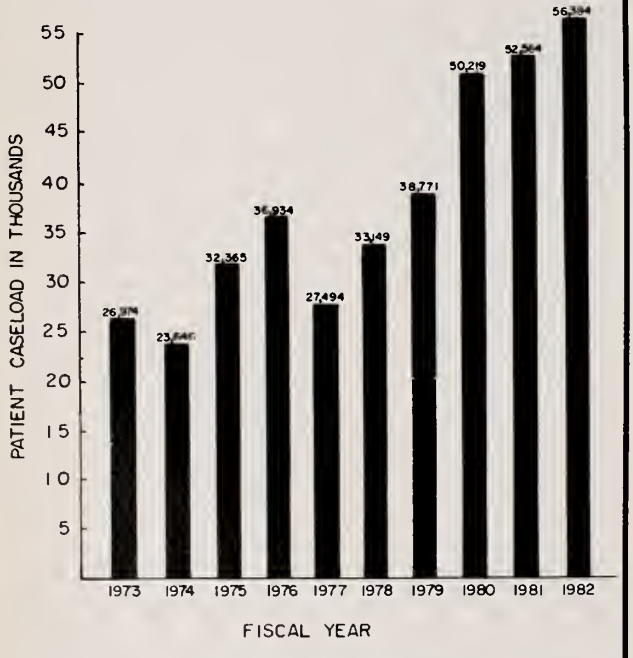


Fig. 1 — Number of patients sponsored by Children's Medical Services in its first decade, 1973 through 1982.

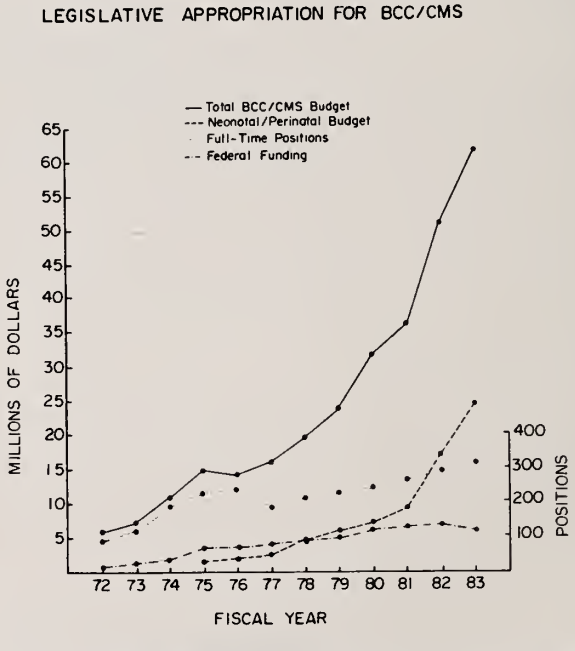


Fig. 2 — State legislative appropriation to the Bureau of Crippled Children/Children's Medical Services, 1972-1983.

Table 2. — Florida Legislative Appropriation for the Bureau of Crippled Children and Children's Medical Services, 1972-1983.

FY	Total	Neonatal/ Perinatal	Federal*	Full-Time Positions
		Millions of dollars		
1972	6.80	–	1.11	95
1973	7.25	–	1.49	117
1974	10.70	–	1.67	192
1975**	14.74	1.50	2.94	225
1976	14.02	1.67	3.11	227
1977	15.03	2.36	3.24	186
1978	18.97	4.38	4.05	207
1979	23.44	5.28	4.81	224
1980	31.49	7.40	6.46	249
1981	35.63	8.84	6.65	257
1982	50.99	17.06	6.95	293
1983	66.50	24.50	5.73	388‡

*Title V and Title XX S.S. funds.
**Until 1975 it was the Bureau of Crippled Children; in 1975 it became the Children's Medical Services.
‡Includes 24 REACH Project positions.

one of the Medical Directors and who is responsible to the HRS District Administrator for supervising all CMS employees and programs for the district. The CMS Program Supervisor/Medical Director is the only part-time state employee responsible for full-time employees. This unique relationship between physicians in private practice and government has worked exceptionally well over the years; indeed, success of the CMS program has often been attributed to this association. Each district has cadre of nurses working under a Nursing Director; with their clerical support this staff comprises most of the full-time employees.

The District Medical Directors (DMDs) are physicians, either pediatricians, orthopedists, or surgeons, whose primary professional interests are the care of children. They are permanent residents of the local communities in which they practice. The DMD selects community physicians and surgeons, dentists, and health-related professionals whose consulting services are purchased for the care of patients. These consultants are chosen using standardized criteria from the official rules and regulations of CMS. Most physicians who qualify have been certified by their respective specialty and subspecialty boards.

Table 3. — Patient Distribution 1981-1982.

Total Unduplicated*	**40,651**
Program Category	
Cardiac	4,356
Child abuse (not child protection team)	13
Cystic fibrosis/pulmonary	285
Diabetes	378
Genetics	508
Hematology/oncology	842
Neurology	3,891
Orthopedics	10,365
Pediatric (general)	20,051
Perinatal	3,046
Renal	1,941
Speech/hearing	4,639
Vision	4,143
Total**	**54,458**

*Total unduplicated represents the total number of patients seen.
**Total represents numbers of conditions seen in some cases, children had more than one condition.

The State Director is responsible to the Assistant Secretary for Program and Planning of HRS. The present Director is a pediatrician who has been in private practice for many years in Florida. Having been a consultant, he understands the unique relationship between government and the private sector that has allowed successful functioning of the CMS program. He oversees program planning and development and maintains statewide standards for care through periodic monitoring of district activities. He receives advice on each statewide program from advisory committees which also provide standards of care in special program areas and promote establishment of multidisciplinary comprehensive care programs.

Each DMD shapes the program in his service delivery area using the best clinical resources available. When resources for a particular patient are not available, the child is referred to a statewide center. This local direction along with statewide supervision by the Director has proved effective.

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The persistent hypoglossal artery in ischemic intracranial cerebral vascular disease

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ABSTRACT: Two cases of persistent hypoglossal artery associated with intracranial cerebral vascular disease are presented. The first patient presented with TIA's and in order to safely perform an endarterectomy a bypass shunt was needed to maintained blood flow to the posterior circulation supplied only by this anamolous vessel. The second patient had a cerebral vascular accident, whose recovery was promoted by the presence of collateral circulation through the persistent hypoglossal artery. The persistent hypoglossal artery is a developmental anamoly which becomes clinically significant only when it is associated with occlusive cerebral vascular disease or some other life threatening vascular abnormality.

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The primitive hypoglossal artery exists for approximately seven days as an anastomosis between the formative elements of the basilar and carotid circulations in the 4 mm human embryo. With a persistent hypoglossal artery, the vertebral artery tends to be hypoplastic and the basilar artery receives blood almost exclusively from the anomalous vessel and, thus, from the carotid artery. The importance of this combination of lesions is evident considering the anatomic consequences. Under these circumstances, the blood supply to the upper brain stem, cerebellum and ipsilateral hemisphere comes from a single vessel. The associated absence of the posterior communicating artery further reduces potential collateral pathways.

We present two cases where the persistent hypoglossal artery is associated with internal carotid artery disease, one a small atherosclerotic plaque and the other a complete occlusion.

Report of Cases • **Case 1.** — A 41-year-old right-handed woman presented with recent history of transient ischemic attack. She was in excellent health until three weeks prior to admission when she noted weakness in her right arm and leg after playing tennis. This lasted overnight with complete resolution. Past medical history was remarkable only for heavy smoking. The neurologic and general physical examination was within normal limits. No bruits were detected. Doppler examination revealed mild turbulence in the left internal carotid artery. Carotid arteriography revealed a 2 mm plaque at the origin of the left internal carotid artery. A persistent hypoglossal artery on the left was also present supplying the entire basilar circulation (Fig. 1). Both vertebral arteries and posterior communicating arteries were atretic. The patient underwent an endarterectomy with a bypass shunt placed across the bifurcation area in order to prevent posterior circulation ischemia. EEG monitoring performed throughout showed no change in her normal pattern. The postoperative course was uneventful and she has had no further symptoms in the year since surgery.



Fig. 1 — Selective left common carotid arteriogram reveals a persistent hypoglossal artery and a 2 mm atherosclerotic plaque at the origin of the internal carotid artery. (case 1).

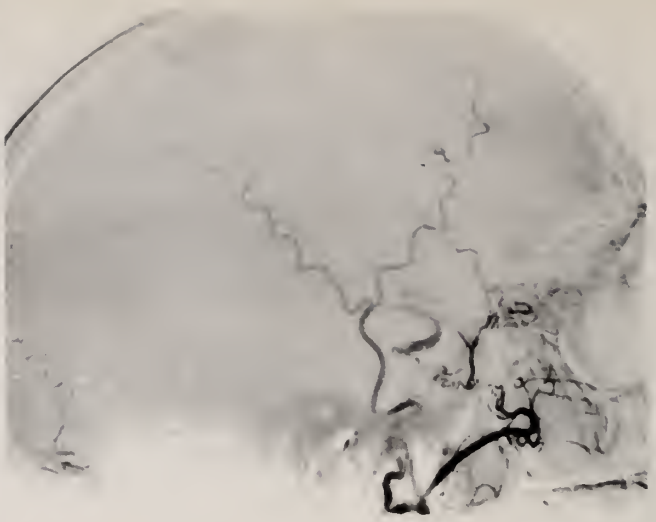
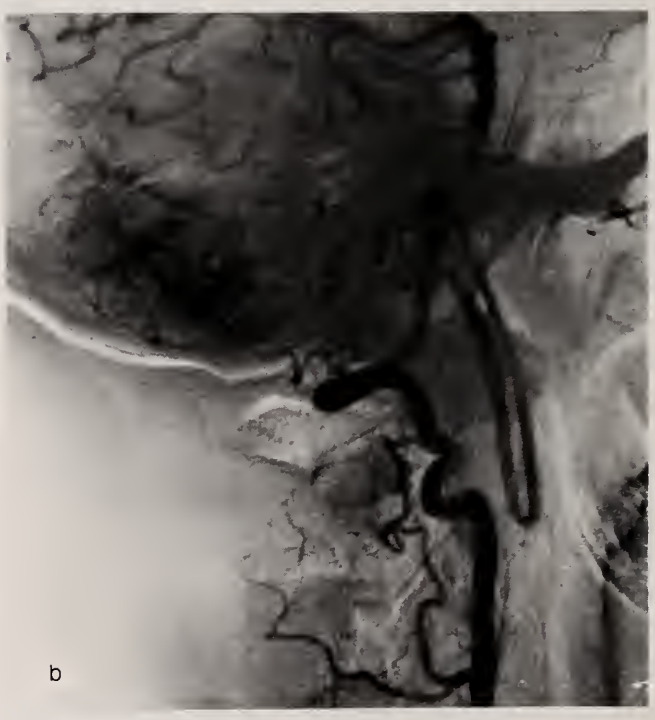


Fig. 2 — Right common carotid arteriogram (lateral projection), (case 2). The right internal carotid artery is occluded at its origin, ethmoidal collaterals (single arrow) allow some forward flow in the right internal carotid artery (double arrows).

Case 2. — A 56-year-old man presented with left hemiparesis of acute onset which partially resolved over two weeks. The patient subsequently had residual weakness in his left arm and an expressive aphasia. There was no evidence of previous vascular disease and no relevant past history. No vascular bruits were detected. Carotid and vertebral arteriography demonstrated that the right internal carotid artery was completely occluded at its origin (Fig. 2). A persistent right hypoglossal artery (Fig. 3 a,b) was responsible for continued but reduced perfusion of the right internal carotid artery territory intracranially. A small intracranial collateral contribution was present from



a



b

Fig. 3 — Left vertebral arteriogram. (a) Anteroposterior projection. Retrograde filling of right vertebral, persistent right hypoglossal artery (arrow) and right internal carotid artery (double arrows). (b) Lateral projection. The persistent hypoglossal (arrow) and right internal carotid artery (double arrows) are well demonstrated.

ethmoidal branches of the right external carotid artery. The proximal right vertebral artery was hypoplastic and unable to be catheterized. Conservative therapy was instituted.

Discussion • In the human embryo there are several communicating vessels that comprise the primitive cerebral circulation. During development these vessels normally occlude and establish the mature cerebral blood flow. In the embryo at 4 mm size (30 days) the blood supply to the brain stem is derived from primitive longitudinal vessels. These vessels are connected with four anastomotic branches: primitive trigeminal artery, otic artery, hypoglossal artery, and the proatlantal intersegmental artery. Subsequently (30-40th day) a vessel is formed between the most cranial portion of these two longitudinal arteries — the posterior communicating artery. At the same time, obliteration of the primitive communicating system begins. After the 40th day, the anastomotic vessels are closed and the normal mature anatomy is present. Failure of closure of one of these anastomotic vessels is a rarity and results in a major caroticobasilar communication.[1]

The apparent frequency of persistent carotid-basilar anastomoses is in the same order as their normal regression. The short-lived otic artery has been incontrovertibly demonstrated only once in postnatal life.[2,3] The trigeminal artery is normally the last to regress and, of the primitive anastomoses, is hemodynamically the most important. This is also the most common persistent anastomosis with about 300 cases reported.[4] Intermediate in both embryotic duration and frequency of abnormal persistence is the hypoglossal artery with over 70 cases being reported.[5] A persistent proatlantal intersegmental artery is extremely rare.

The persistence of a hypoglossal artery has primarily been reported as an incidental observation at the time of carotid arteriography, although it has been associated with transcient ischemic attacks and aneurysms.[6] Lie[7] proposed four angiographic criteria for diagnosis of a persistent hypoglossal artery:

1. The artery must be a robust branch of the internal carotid artery arising from its posterior aspect at the level of the C-1 through C-3 vertebral bodies.
2. The artery must enter the skull through the hypoglossal canal.
3. The basilar artery must fill only distal to the entrance of the abnormal artery.
4. The posterior communicating artery must not appear on the angiogram.

The last two requirements do not appear to be absolute.

When lesions requiring surgical therapy are discovered in patients with a persistent carotid-basilar anastomosis, recognition of the aberrant arterial supply to the brain stem is critical. This anomaly precludes ligation of the carotid arteries to treat certain aneurysms or to perform an endarterectomy. Pinkerton[8] described endarterectomy with monitoring and bypass with a temporary in-lying shunt. Carotid occlusion during endarterectomy has a potential effect on blood flow to the posterior circulation due to the minimal collaterals present.

In case 1, the persistent hypoglossal artery was an incidental but important finding in regard to the planned surgical approach. In order to safely perform the endarterectomy a bypass shunt was needed to maintain blood flow to the posterior circulation supplied only by this anomalous vessel when the carotid artery is cross-clamped.

In case 2, the acute onset of the left hemiparesis and its gradual recovery suggested a vascular event. The recovery appears to have been promoted by presence of the persistent hypoglossal artery and development of ethmoidal collaterals. These vessels allowed a continued but somewhat diminished perfusion of the intracranial territory of the left internal carotid artery. Lesions of the internal carotid artery associated with a persistent hypoglossal or trigeminal artery have been noted previously and are of clinical interest in that they may produce ischemic episodes in both basilar and internal carotid artery territories.[6,9,10]

The persistent hypoglossal artery is a developmental anomaly which becomes clinically significant only when it is associated with occlusive cerebral vascular disease or some other life-threatening vascular abnormality.

Acknowledgment

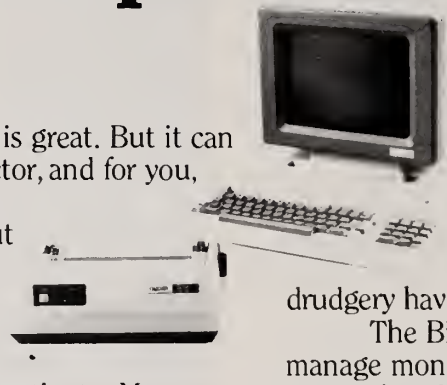
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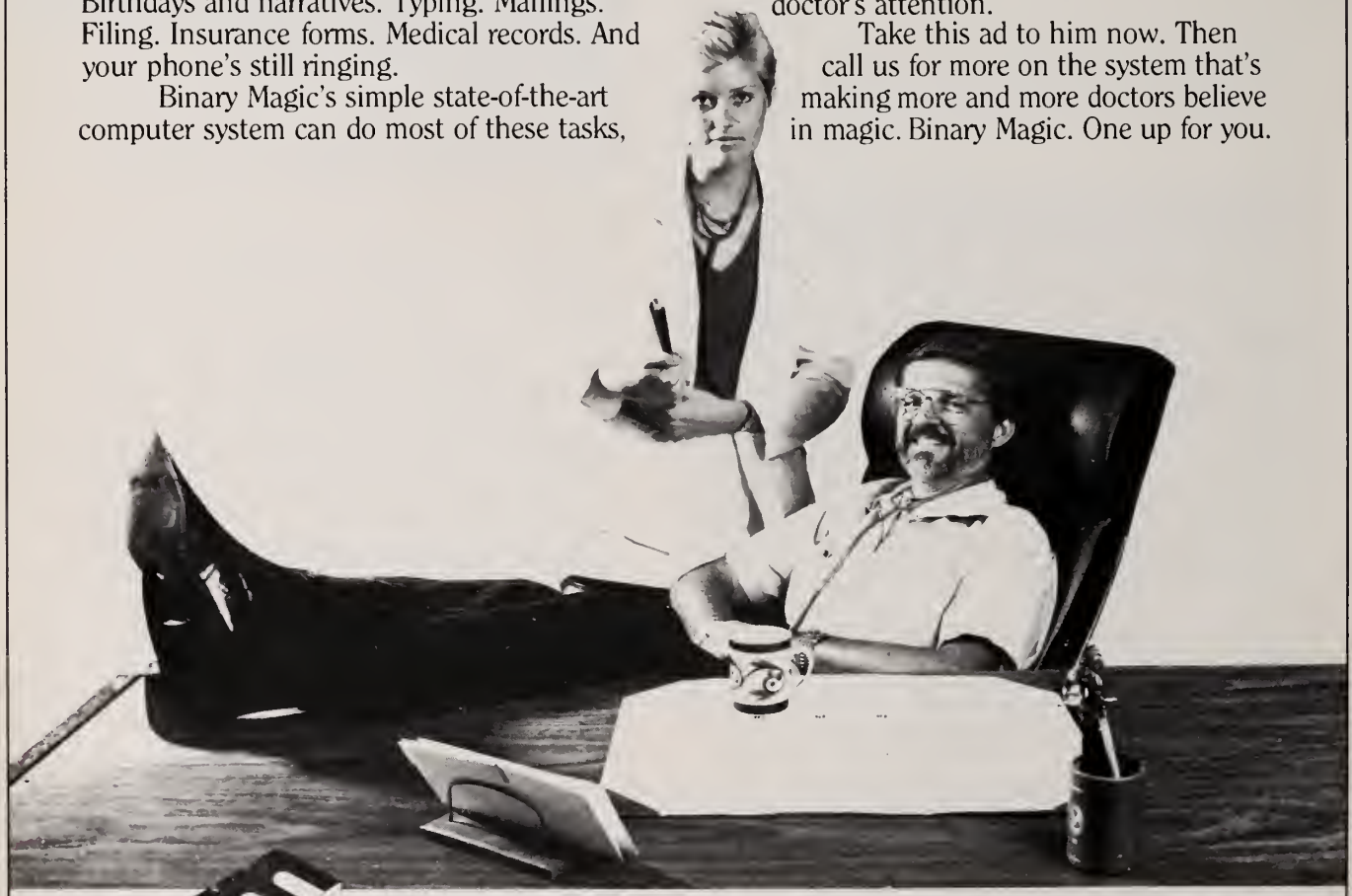
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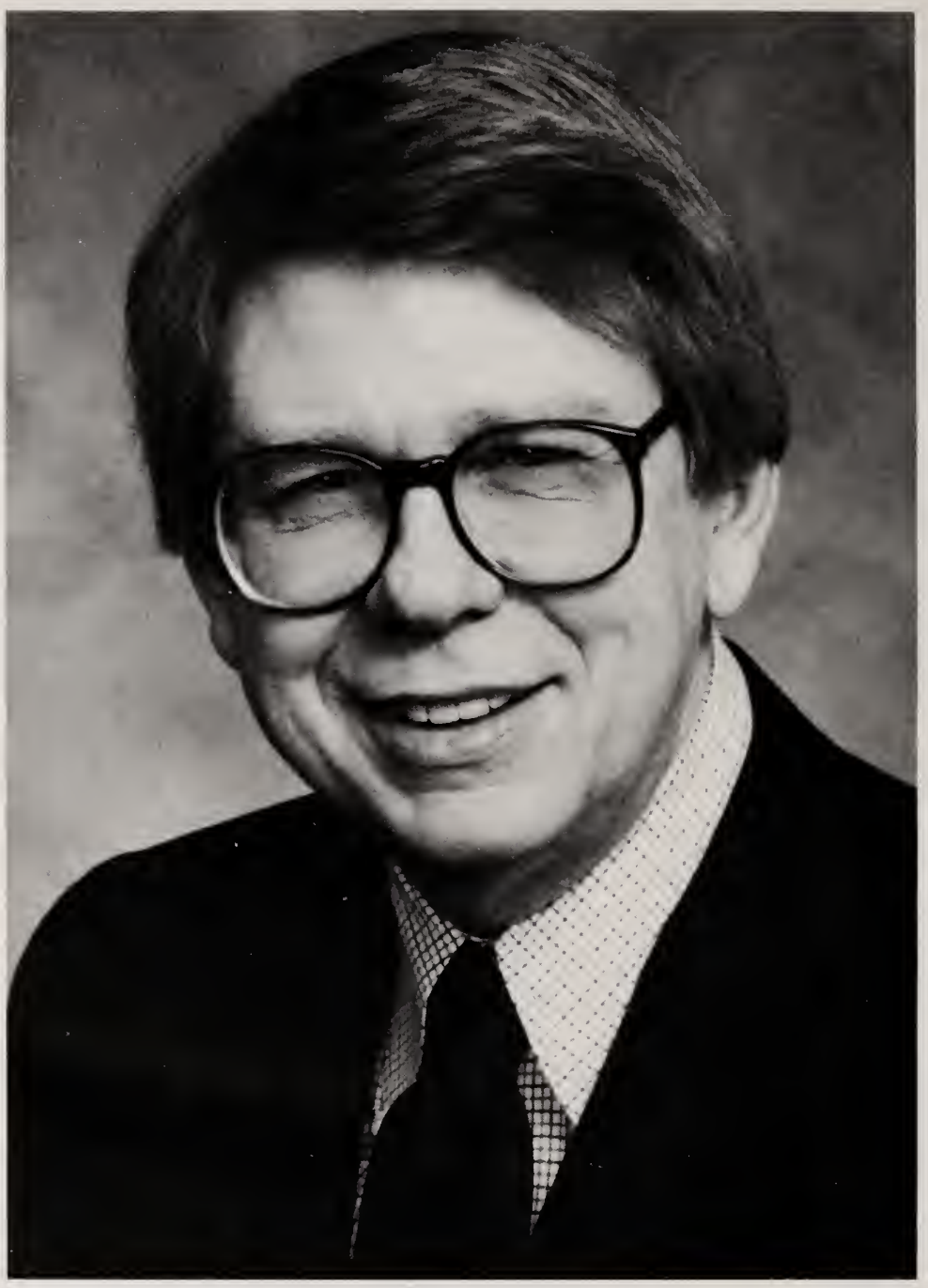
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Daniel B. Nunn, M.D.
Editor
The Journal of the Florida Medical Association, Inc.
1980 — 1985

SPECIAL ARTICLE

A job well done

T. Byron Thames, M.D.

Five years ago, as the incoming President of the Florida Medical Association, I was called upon to make one of the most important appointments of my year as President. That appointment was to be the Editor of *The Journal of the Florida Medical Association*. The new Editor was to follow in the footsteps of an eminently qualified Editor who had brought *The Journal* to new heights of scientific excellence and communication for the membership of the Florida Medical Association. Many people expressed doubt that any Editor would be able to follow in the footsteps of this individual and continue the preeminent position of *The Journal of the Florida Medical Association*.

I was given the choice of a number of qualified individuals throughout the State who might be prevailed upon to serve as Editor of *The Journal*. After reviewing all of them, I was particularly impressed with the qualifications of Dr. Daniel B. Nunn, of Jacksonville. He had been serving as Editor of *Jacksonville Medicine*, the Duval County Medical Society Bulletin from 1977 to 1979. I had the benefit of being able to read many of these issues and determine for myself that it was a quality publication, well edited.

The Author
T. BYRON THAMES, M.D.
Dr. Thames is a Past President of the Florida Medical Association, Inc. and he is a practicing family physician, Orlando.

Dan Nunn is a Southerner, having been born in Columbia, South Carolina and graduating from the University of South Carolina with a Phi Beta Kappa, Magna Cum Laude degree in chemistry. He attended the Medical University of South Carolina, graduating in 1955 as an Alpha Omega Alpha. He took his internship and general and thoracic surgical residency and a Fellowship in vascular surgery at the Medical University of South Carolina.

Dan is a Diplomate of both the American Board of Surgery and the American Board of Thoracic Surgery. In 1983, he was among the first group of vascular surgeons selected to take the new specialty examination in general vascular surgery. He successfully completed the examination and was awarded a certificate of special competence in vascular surgery by the American Board of Surgery. He is also a fellow of the American College of Surgeons.

Dan has been active in medical circles, serving as Chief of Staff at Methodist Hospital, Jacksonville, from 1976 to 1977. He has been Chief of Thoracic and Cardiovascular Surgery at Methodist Hospital from 1971 to 1985. He is a Clinical Associate Professor of Surgery at the University of Florida Medical School in their Jacksonville Hospital's Educational Program.

Dan holds all of the memberships in the well known medical and surgical societies, including the American Medical Association, Florida Medical Association, Florida Society of Thoracic and Cardiovascular Surgeons (Past President), and the Southern Thoracic Surgical Association. In addition, he belongs to the Society of Thoracic Surgeons, the International Society of Cardiovascular Surgeons, and is a charter member of the Southern Association for Vascular Surgery, limited to 150 members in thirteen Southeastern states. He is also a member of the

Society for Vascular Surgery, in which the membership is limited to 250 members in the United States and Canada, and the Southern Surgical Association, which is limited in membership to 300. He had served as an investigator in cardiovascular research at Walter Reed Army Institute of Research in 1961 to 1963, and was a winner of the Medalist paper for the forum on Progress in Surgery at the Southeastern Surgical Congress Meeting in 1961.

Dan had all the background and qualifications, but I knew him in a very remote way, not having been a personal acquaintance or friend, but having seen him only occasionally through the Florida Medical Association. I am pleased to say that in my association during the following five years I have come to know Dan as a personal friend and to enjoy the fellowship of his family and himself in his home and through many meetings of the Florida Medical Association. I was fortunate to have made the choice of Dan Nunn for Editor of *The Journal of the Florida Medical Association*, and Florida medicine has benefitted greatly by his acceptance of this position upon my request.

As Editor of *The Journal* he has controlled the articles which were published in *The Journal*, with the assistance of his Board. The outstanding quality of manuscripts and scientific publications has continued to rank *The Journal of the Florida Medical Association* as a premiere production in its field.

In addition to choosing the scientific manuscripts which are accepted for publication, the Editor of *The Journal* has to be a good businessman. The cost of publishing *The Journal* has gone up tremendously and the amount of money to be raised by sale of advertising and making *The Journal* readable is one of the great tasks of the Editor, as well as satisfying the Board of Governors of the Florida Medical Association that he can live within his budget.

I was pleased in my year as President with the way Dan Nunn was able to handle this. I know the succeeding Presidents of the Florida Medical Association who have reappointed him for the following four years as Editor must have felt the same way. He completely redesigned *The Journal* and won the Sandoz Award in 1983 for the best State Medical Journal in the United States. The advertising income was consistently outstanding. Dan Nunn learned not only to live within the budget, but to insist that other members of the Editorial Board and guest editors live with their deadlines also. He was able to assist the Board of Governors in its many excellent specialty issues by choosing the outstanding guest editors who served with him.

Dan Nunn personally has had 76 scientific articles and 28 editorials published over the time in which he has been Editor of *The Journal* and prior to this.

In addition to presenting scientific material to the membership, the other job of *The Journal of the Florida Medical Association* is to present to the membership what is happening in the world of medicine and the legislature and other areas which affect the practice of medicine in the State of Florida. Under Dr. Nunn, *The Journal* during the last five years has consistently given up-to-date, valuable and accurate information about the activities of the Board of Governors, and officers of the Medical Association to the membership at large, and has kept them apprised of the primary issues involving the practice of medicine.

Dan Nunn did a superb job for me as Editor of *The Journal of the Florida Medical Association*. He did an excellent job for the succeeding four Presidents of the Florida Medical Association. He has now finished his five-year term as Editor of *The Journal of the Florida Medical Association*, and because of the restriction placed on this term by the Board of Governors, can no longer serve as your Editor. More than what he did for me and the other Presidents, Dan Nunn has served the membership of the Florida Medical Association in an untiring way through countless hours of activity and through his continuing energetic leadership of *The Journal*. Every member of the Florida Medical Association owes him a debt of gratitude. I hope you will drop him a note and express to him your personal gratitude, as I have, for the tremendous job he has done for all of us in Florida medicine. We look forward to his continued efforts on our behalf in whatever way he feels may serve us best.

● Dr. Thames, Post Office Box 8908, Orlando 32806.

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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae*) and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae,* staphylococci, and *S. pneumoniae*; Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli, P. mirabilis, Klebsiella* species, and enterococci (*S. faecalis*).

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

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Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Hematologic — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structure infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h). For dosage recommendations in patients with impaired renal function, consult package insert.

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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☐ NOTES & NEWS

Burns A. Dobbins Jr., M.D. 1915 — 1985

The following tribute was written by long-time friend Charles K. Donegan, M.D. of St. Petersburg.

Burns A. Dobbins, M.D., passed away suddenly on March 12, 1985, shortly after attending the Board of Governors meeting of the Florida Medical Association in Tampa, Florida on March 9, 1985.

Dr. Dobbins graduated from the University of Florida at Gainesville in 1935 and from Temple Medical School in 1939. He had his internship at Philadelphia General Hospital, and his residency at Columbia Presbyterian Hospital. During World War II, he was in the United States Navy attached to the 88th Naval Construction Battalion and was discharged as a Lieutenant Commander in the Medical Corp. Shortly after this, he came to Fort Lauderdale, where he was one of the county's first pediatricians and retired in July, 1984. He was active in many civic organizations through the years, especially those related to children, too many to be enumerated.

Dr. Dobbins served on the Broward County Medical Association Board of Trustees from 1950-1955, and on the Board of Census from 1955-1958, and as Broward County Medical Association President from 1960-1961. Dr. Dobbins served the Florida Medical Association as a Delegate to the AMA from 1959 to the time of his death. He was a member of the Council on Medical Services of the AMA from 1963-1972. He was on the Judicial Council by an appointment made by the President of the American Medical Association from 1972-1982, and was Chairman of the Judicial Council of the AMA from 1977-1979. Dr. Dobbins also served at the national level on the national Blue Shield Board for several years.

Dr. Dobbins was awarded the Broward's Physician of the Year by the Caducean Society, an exclusive, closed medical education group composed of two select physicians from each Broward County specialty. He was recognized for his outstanding service to the community in the field of medicine in 1976. It was noted that he cared for many thousands of Broward's youngsters and was then in 1976, caring for their children. He was Past President of the Florida Pediatric Society.

Dr. Dobbins was active in the Florida Medical Association throughout his medical career and was appointed to the Peer Medical Utilization Committee at its beginning in 1971 until his death and served on that committee as Vice-Chairman the last few years. Dr. Dobbins was the first Chief of Staff at Plantation General Hospital and served as the Chairman of the Board there from 1966-1983. In addition, he was Chief of Pediatric Staff at the Broward General Medical Center, where he first began practicing in 1946. Dr. Dobbins was founder and director of Home-Owners Life Insurance Company and the United Federal Savings and Loan Association, which is now known as California Federal.

Dr. Dobbins was very active in boating circles; held offices at the Coral Ridge Yacht Club and was President of the Harbor Beach Surf Club and as fleet surgeon for the Lauderdale Yacht Club. He was noted for his dry wit; he always described himself as a nickle-and-dime doctor to illustrate pediatrician's fees were much lower than the average physician. Dr. Dobbins will long be remembered by the medical community on the local, state and national levels. He is highly respected for his contributions, not only to medicine, but in his civic duties as an elder, trustee and deacon of the First Presbyterian Church of Lauderdale and was a member of the Board of the Westminister Choir College of Princeton, New Jersey for many years.

Dr. Dobbins is survived by his wife, Estelle, son Burns Alan Dobbins III, who is an attorney in Fort Lauderdale, and his son Timothy, a minister of the Presbyterian Church. He is also survived by daughter-in-law, Marion, two grandsons, and a sister.

FMA receives plaque for AMA membership increase

On behalf of the Florida Medical Association, FMA President Frank C. Coleman, M.D. received a plaque earlier this year from John Coury, M.D., Chairman of the American Medical Association Board of Trustees, in recognition of FMA's increase in memberships in the AMA for the seventh consecutive year. Florida had 10,895 physicians on the AMA membership rolls in 1984, a gain of 424 over 1983.

Robert T. Watson, M.D. wins 1985 Hippocratic Award

Graduating seniors at the University of Florida College of Medicine presented on April 25 the 16th Annual Hippocratic Award for Teaching Excellence to Robert T. Watson, M.D., a professor of neurology, neuroscience, and clinical psychology at UF.

Chosen for being a teacher that "stimulates the soul and inspires the mind," Dr. Watson received an engraved plaque during the traditional ceremonies held on the front lawn of Shands Hospital.

A native of Nashville, Tennessee, Dr. Watson earned both his B.S. and M.D. degree at UF. He completed his internship at the University of Alabama Medical College and University Hospital before returning to UF's College of Medicine to finish his residency. Except for the three years he was in private practice beginning in 1977, Dr. Watson has been a part of UF's Medical School faculty since 1973.

Dr. Watson is an alumnus of UF's 1969 graduating class which established the award named for Hippocrates, the fifth century Greek physician highly revered for his effective teaching and compassionate patient care.

DEAN'S MESSAGE

Tropical medicine in semi-tropical Florida

Tropical Medicine encompasses a heterogeneous group of diseases, mostly infectious, that are either unusually prevalent in the tropics or are caused by parasites even if they are epidemiologically temperate zone problems. In either case, with rare exceptions, they are uncommon problems in the continental United States. Many of these infectious diseases are the products of underdeveloped public hygiene and resource limitation which plagues the Third World. An equal share are, however, limited to the tropics by climatic and environmental factors that determine the distribution of essential insect, mollusk and mammalian intermediate hosts. In fact, the limited prevalence of tropical disease in this country focuses on international ports of entry with their attnedant immigrant populations and in those few sunbelt areas that by climate are truly tropical. In this sense, Florida receives a double dose of exposure. Infections brought by U.S. citizens vacationing or working abroad are a minority.

In spite of Florida's unusual prevalence of tropical afflictions even here they remain too scattered and infrequent to support, in private practice, specialists in tropical diseases or to provide Florida primary care physicians with the sustained experience needed to deliver optimum care. Diagnosis and management of tropical diseases is a responsibility accepted by Florida's Colleges of Medicine. Faculty status, teaching needs and research programs provide the schools the justification for maintaining tropical disease specialists. In areas geographically removed from medical schools, county health departments are often called upon to support this service. On the whole the quality of care delivered to patients with these exotic diseases is excellent, although it may occasionally be clumsy to access.

The colleges of medicine have a second much less appreciated role, the prevention of establishment of foci of tropical diseases. The semi-tropical environment of southern Florida has already proven receptive for exotic tropical immigrants such as walking catfish, giant frogs, the melaleuca tree and a termite with a willingness to consider cement. It can be an equally receptive environment for filariasis, malaira, dengue fever and yellow fever, all of which though limited by the requirement for specific insect vectors for transmission are easily accomodated by our rich tropical fauna.

The traditional bastion against establishment of such diseases has been slow travel and quarantine, both of which are victims of technologic progress. Only good luck has prevented the establishment of endemic foci of tropical disease in Florida. Perhaps as a reminder cholera, now known to be a long term resident in Florida's estuaries, has recently re-emerged to cause sporatic human disease. Budget constraints have steadily eroded federal government resources, largely in the National Centers for Disease Control, that have in the past bolstered surveillance and control. It would be timely to consider the level of local support for research and surveillance of these seemingly exotic problems.

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WORTH REPEATING

Alternative care systems: a commentary

The wind bloweth where it listeth, and thou hearest the sound thereof, but canst not tell whence it cometh, and whither it goest . . .

—John 3:8

Alabama physicians, like John, know the winds of change are upon them, but they do not know whither they blowest.

Alternative care systems, in earlier incarnations, have been around for a long time, certainly since the early 1900s, if one counts medical care foundations. Not until 1983, however, did the federal government, in its infinite wisdom, produce the pressure that generated the rush to create all manner of new marketplace prostheses.

It may be instructive to go back a few years to review the conventional economic wisdom that was the background against which the New Order has been so hastily built. The medical marketplace, just about everybody was saying, represented an inversion of classical economic theory. If competition increased by expanding the number of providers, prices should go down. But in the perversity of the medical marketplace, they go up. Similarly, the theory of Economies of Scale should mean, the high-domed economists said, that increased volume brings unit costs down. Instead, they skyrocketed.

The medical marketplace simply refused to comport with any economic model. When GMENAC predicted a physician surplus, those untaught in the perversities of the medical marketplace said that when the supply of services is greater than the demand, prices would fall. The topsy-turvy theory of the medical economics said they would rise still higher, since everything is reversed in this world of Alice Beyond the Looking Glass.

When the alarmed business community began closely studying the health care they were buying for their employees, when they understood that all the usual economic laws are either suspended or reversed, they too, in common with the federal government, began to think of price control.

Alternative systems, whether favored by government or industry, whether created by actuaries, third party payors or physicians, mean *price control* by definition. Implicit in all of them are these ideas: avoid hospitals wherever possible, by preadmission certification, by inducements to preventive medicine, by imposing hospital stay norms through DRG, by whatever device. The first disideratum is to avoid hospitals, if possible, and to curtail use when avoidance is impossible.

Another common denominator in alternative care systems, including those with hospital contracts, is a discount in some form. The physician is asked to reduce fees, to accept the concept of a ceiling on fees (usually less than actual charges), to agree to a schedule, or several of these in combination. In short, he is being asked, under duress, to cut his prices. So is the hospital. Those third party payors, or their agents, with the most market leverage, the most clout, can often get the best deal.

Assume, for the sake of argument, that hospitals *can* squeeze a little out of their present charges without going into the red or seriously compromising quality. A little, I said. Many payors are demanding a lot, just as the government has been demanding special consideration for its patients.

Until recently, it was possible to shift Medicare costs to other payors. Now it is these very o*ther* payors who are themselves demanding what can only result in more cost shifting. Since the free lunch has been pretty well proven to be nonexistent, what is going to happen if every payor demands price concessions and no one is left to shift these costs onto? The United States may now be at that point. If a hospital, to meet its competition, grants concessions and runs out of shiftees, nothing is left to do but go out of business. Some experts are saying some hospital failures will be inevitable in any case. It seems just as likely that, if there is a physician surplus, some physicians may go out of business as well.

Suppose these closings do occur, and the medical marketplace then begins acting like the classical marketplace. Demand continues to rise while supply falls. Isn't it just possible that the same thing will happen as happens in the cattle market, in the real estate business, and in general retailing when there are too many dollars chasing too few goods? That is the classic definition of inflation, and it is far more likely to be the macro-economic result, over time, than the aggregate of the micro-economic savings, here and there, by each payor concerned primarily with immediate price.

A leading health cost specialist, writing in the *Harvard Business Review* of January/February 1984, predicts just this, and more. Richard H. Egdahl, M.D., director of the Boston University Medical Center, says that alternative care systems, designed to save money, will ultimately *increase* costs because they simply expand the system. The system must contract, he says, if industry and government are to realize a reduction in price. "Costs, both fixed and variable, associated with unused capacity must be removed from the system rather than built into the price of the remaining services delivered," he writes.

Egdahl finds that many of the alternative delivery systems appear, at first, to result in savings but actually do not. Ambulatory surgical facilities offer an example. Although he concedes that 20 to 40 percent

of the surgical procedures traditionally performed in hospitals can be done safely in ambulatory facilities, where they have been in place for a time, this reduction in inpatient procedures has not occurred. There are several reasons: (1) the considerable variability in the use of elective surgery; (2) a surplus of surgeon specialists in many metropolitan areas where, according to studies, a direct correlation exists between the number of surgeons and the number of surgical procedures performed; (3) an increase in the rate of hospital operations as well as ambulatory surgery on a per capita basis; (4) physician competition, which has led to successful marketing techniques from that of increasing "the public's desire for elective surgery."

Additionally, Egdahl says, some hospitals have established outpatient surgical programs, but these have not "decreased inpatient surgical capacity." On the contrary, "net increases in surgical volume (and overall expense) have often been the result."

What all this means, Egdahl says, "is that the saving from carrying out ambulatory surgery must depend on some kind of overall community agreement about limiting *total* surgical volume, and that agreement simply does not exist." The alternative systems result in expanding the system, not shrinking it, and also result in enhancing demand instead of bringing it down. Unit prices may look great, but the bottom line keeps swelling.

Industry, Egdahl says, has succeeded in many communities in reducing admissions, length of stay, and unit cost. But with what result? The average cost per hospital day goes up and hospital capacity is freed for other patients. Hospitals, like nature, abhor vacuums, and somehow that capacity will be used. The hospital's first duty, like any institution, is survival.

"Thus," he says, "while a company may reduce its costs for the particular patient served, unless there is programmed shrinkage of hospital capacity and related staffing costs, there will be no system savings and probably a cost increase for the community." Once again, that company has simply muscled a cost shift to somebody else, and the somebody-elses are getting fewer and fewer.

Lab tests are another quandary, he writes. Reducing lab tests without "reducing laboratory staff and equipment purchases will not result in savings and may result in increases to the rest of the community."

These and other actions by government or corporations do not result in o*verall* savings. Support for health planning initiatives, such as rate setting and capital expenditure constraints; competition, such as that provided by HMOs and PPOs; redesigned health plans; individual cost-management programs, such as second surgical opinions; bonuses to employees for not using health benefits; and analysis and negotiation of large and potentially excessive insurance claims will not create *community* cost savings.

What will? Nothing, Egdahl believes, but draconian methods similar to a controversial law passed in Massachusetts in 1982, which simply froze hospital budgets at levels that forced hospital layoffs, forced deferral of maintenance, and reduced new hospital programs.

What this theory means nationally, and Egdahl seems to believe there is no other way, is that a lot of hospitals, doctors, nurses, administrators and others will have to be forced out of business.

Then what? What usually happens after such freezes is that pent-up demand finally blows off the constraints, one way or another, and the resulting expansion creates inflationary cost add-ons that not only erase whatever savings might have been but also dramatically increase costs over time.

Alabama State Health Officer, Dr. Ira Myers, has been in public health longer than anyone else at this level in any state. From this vast experience he has evolved Myers law: "Whatever works, won't work long."

This sentiment among confused physicians accounts for much of their dismayed belief that the wind bloweth where it listeth and none can know what will survive. In the short term, physicians are not so much interested in what the various contracts offer them *this* year. They wonder about next year, and the year after, when all the magic solutions begin to sour, as Egdahl suggests they will, and even more heroic sacrifices are required of physicians. Who will be left holding every bag? Physicians receive less than 20 cents of the total health care dollar but, seemingly, already get about 80 percent of the blame dollar. Those ratios are not likely to change.

California has moved toward encouragement of a two-tiered system, but the frantic scrambling for market share by various competing delivery systems there was linked, back in February, to all-out war by one executive, close to the scene.

Robert D. Burnett, M.D., President of the California Medical Association, addressed his comments earlier this year to one aspect of the war. The statewide "Prudent Buyer Plan" by Blue Cross is, he said, "part of the unhealthy trend of the companies with the most muscle getting the largest discounts and the poor guy down the street paying full price." PPOs, he said, "just lead to more cost shifting . . . the same old problem."

Burnett had his own ominous prediction, which may explain some of the anxiety physicians feel about what will happen next year. He said that each succeeding year, Blue Cross "will sign up fewer and fewer physicians and pay an increasingly reduced rate to nonparticipating doctors."

Although patients will be given lists of participating doctors, "they will think insurance, and go for care outside the plan." The more often subscribers go

to nonparticipating doctors, the less it will cost Blue Cross, he said.

In other words, Burnett is saying much of what Egdahl said has been the result of marketing efforts on behalf of freestanding emergency centers: The public gets only part of the message, having little idea of what a PPO is and caring even less.

Egdahl says that a major complicating factor in controlling health care costs is the recent growth in proprietary hospitals, ambulatory care centers, and prepaid health plans:

> It is not hard to accept that potential good can come from introducing the rigors of the marketplace into such large businesses as hospitals, where hundred-million-dollar budgets are common, but it is hard to see where the introduction of profit-making competition into the health care delivery system will redirect health cost trends, since studies suggest that much of the proprietary hospitals' profits come from higher prices and greater use of laboratory tests.

Also, rapid entrance of proprietary companies in the health care delivery area "will undoubtedly result in an additional influx of capital into the systems, adding fuel to the fire." Egdahl continues:

> A major concern about potential future dominance of the for-profits in the health care market relates to their rather narrow focus on making money, rather than the integrity of the entire health care system. A large amount of research and technology development goes on in major nonprofit medical centers.
>
> These are creative and important, albeit expensive, centers for training undergraduate physicians and residents. Nonprofit hospitals also treat the majority of people who cannot afford to pay. These societally important purposes will not be prime objectives for the proprietary hospitals.

The only constant in life, Pascal said, is change. Physicians are no strangers to change, but it is peculiar to their professional experience that change is always fraught with uncertainty. Last year's highly touted new drug or procedure is this year's taboo because of untoward results that no one foresaw. Any physician who has been in practice long enough has developed a suspicion of miracle cures. That easily translates into suspicion of the plethora of economic panaceas.

The paramount consideration in trying to forecast what will come of all this is one revolutionary change: For the first time in the history of the profession, physicians will be paid not to do something instead of doing things. In a way foreign to most physicians, HMOs pay physicians a bonus from the surplus accumulated when medical care is not delivered.

All the incentives so far revealed reward both the patient and the physician for avoiding the hospital. The nonprovision of care, and I can think of no other label for it, is something doctors know nothing about. They were trained to use whatever is needed and available on behalf of patients.

A common assumption seems to run through all the alternative care systems that quality will remain high while quantity of services is reduced. Nobody really knows that. Nor does anyone really know whether access, which has itself been the target of criticism over recent years, will remain about as it is. Physicians have the vague impression, arising from even vaguer national explanations, that the American expenditure on medicine will remain about where it is but the distribution will change. Will those changes make for a higher or lower quality? Only the future will determine that, but I think almost everyone is keeping fingers crossed.

Unless someone can stand back, like King Canute, demanding the waves to halt, improvements in medical technology will continue. Will the impresarios simply tell institutions and the public that they cannot have any more improvements? That is exactly what happened recently when an internationally famous cancer center in the East was denied a Certificate of Need for one of the latest pieces of wizardry, a Nuclear Magnetic Resonance machine. Oncologists say NMR will have a profound effect on diagnosis and therapy because of its clear window on the soft tissues. Imagine the public outcry when patients are said to be denied the chance to live — as may happen — because the NMR is too expensive.

At this juncture, physicians are being asked to ration health care but told this is a transition period and that all may change. Change to what? If American medical resources are to be rationed, by whatever fancy language, who is going to do the rationing over the long haul?

This revolution presents all kinds of ethical Gordian knots. Doctors have been imbued with the sanctity of the physician-patient relationship. The concept of physician as patient's advocate is as old as medicine. Now they are told, "that won't do. It's too expensive." In a trice, the physician is being told that his first duty is to the system, to the hospital, to the DRG, to the bottom line, to whatever.

Legal scholars have already pointed out some pretty dangerous ground under this. Through history, the physician has had the privilege, and the corresponding responsibility, of a virtually inviolate trust relationship with his patient. In some states, this relationship is even codified into statutes relating to fiduciary relationships. It may be manifestly illegal for physicians in some states even to consider a duty above that he owes the patients. In other states, it is certainly a powerful ethical question.

Finally, what is going to happen to hospitals when we cut back on all their profits? Ten years from

now, many nonprofits may be totally outmoded. This could be a time bomb as for-profits and not-for-profits alike skimp on technology, or medical education, or everything, with eyes fixed on the profits-and-losses sheet. As a television commercial declared a few years ago, "Pay me now or pay me later." A small investment now, if ignored, is going to become a whopping one down the road.

In their best-selling book on American management, *In Search of Excellence*, Peters and Waterman point to the short life of companies interested only in the near term. Those companies do not grow, do not expand, contribute little to society, and do not survive over the long haul. But the very myopia the book condemns is what is being asked of the vast and unequalled American health care system. This year's bottom line (and maybe next year's) is as far as managers are asked to look into the future. If physicians and hospitals of a few decades ago had been so programmed, where would our vaunted health care system be today?

Maybe salvation lies in Myers Law: Whatever works won't work long. Maybe the reverse incentive — the incentive to withhold care — will collapse soon enough to spare the country the long-range consequences.

Peter W. Morris, M.D.
Birmingham, AL

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SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us

"Forged or stolen record scam"

Recently investigators in the Kansas City area have interviewed numerous physicians concerning their prescribing of RITALIN for Narcolepsy, DILAUDID for terminal cancer, SECONAL and TUINAL for sleep disorders, etc. In all of these cases the physician had prescribed the controlled drugs based on hospital and/or medical records given to him by the patient.

Checking the copies of these medical records it soon became clear that they had been stolen from several area hospitals. The real patient's name had been covered with correction fluid, a fake name typed, and the form was copied so it looked as though nothing had been altered.

It was determined an organized group of "Professional Patients" were obtaining copies of medical records from a medical records technician who worked at one of the hospitals.

Caution • Physicians are cautioned to make their own diagnosis of patient complaints and problems. Also, previous medical histories should be obtained in writing by the physician from hospitals or other physicians or requested via telephone. Any medical records brought in by the patient should be verified with the physician or hospital involved, especially those indicating treatment with Controlled Drugs.

CORRESPONDENCE

Dear Editor: The purpose of this letter is to ask that your organization publish certain information in *The Journal*.

Florida Statutes provide for the issuance of exemption entitlement parking permits for handicapped or disabled persons. This is provided in Florida Statute 320.48. These parking permits allow the holder to utilize parking places provided by governmental agencies and private concerns for disabled persons.

The requirement for obtaining an exemption entitlement parking permit is that the applicant be "currently certified by a physician or an osteopathic physician licensed in the United States, by the Division of Blind Services of the Department of Education, or by the Veterans Administration as being severely physically disabled and having permanent mobility problems which substantially impair his ability to ambulate or who is certified as legally blind."

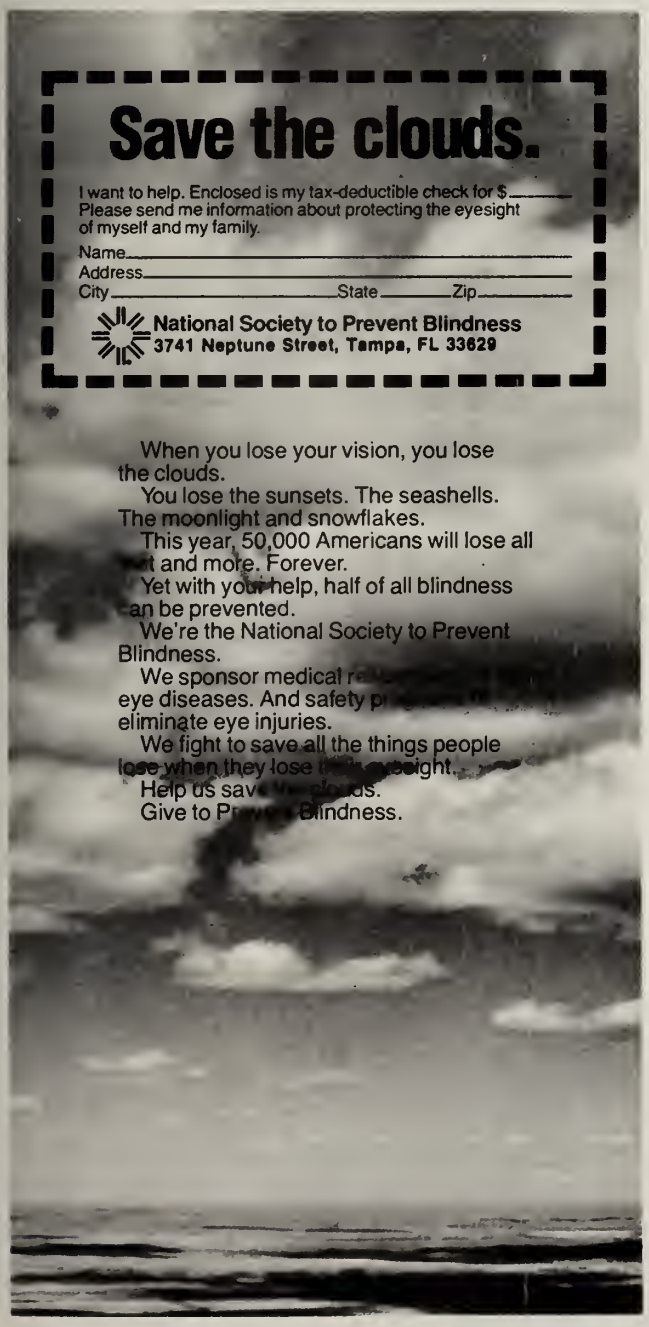
It appears that some physicians are certifying patients even though their condition is not permanent, or does not substantially impair their ability to ambulate.

As a result, there are not sufficient handicapped parking spaces to service all individuals with the exemption entitlement parking permits. Many severely handicapped persons are unable to park in the spaces that were designated for them because less handicapped individuals or non-handicapped individuals have obtained parking permits.

We would respectfully request that your Association remind its members that such certification should only be given when the patient is severely physically disabled, having permanent mobility problems which substantially impair their ability to ambulate or who are legally blind.

We believe that if this is brought to the physicians' attention that the problems can be greatly alleviated.

George H. Snyder
Chairperson
Advisory Board for the Disabled





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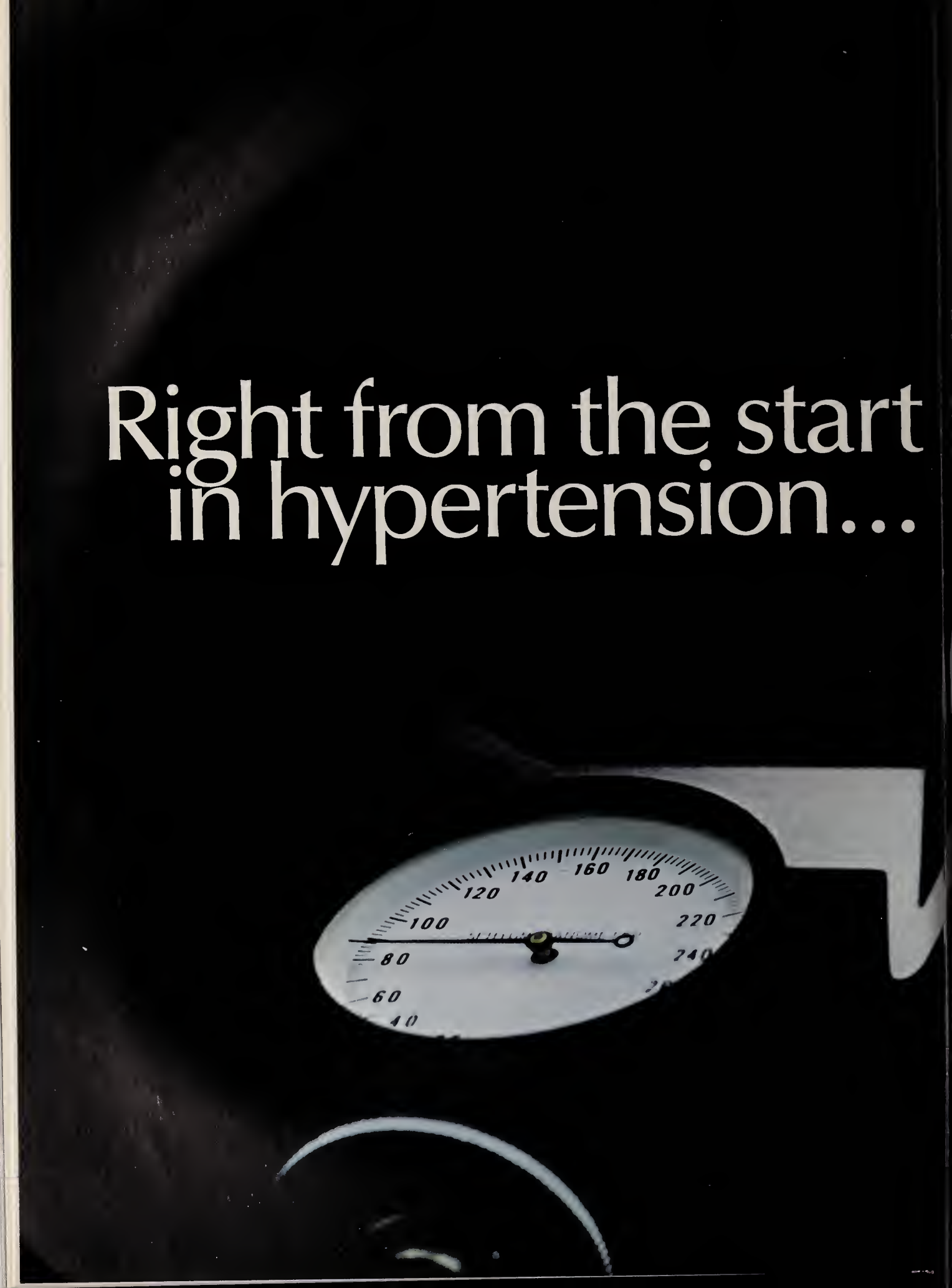
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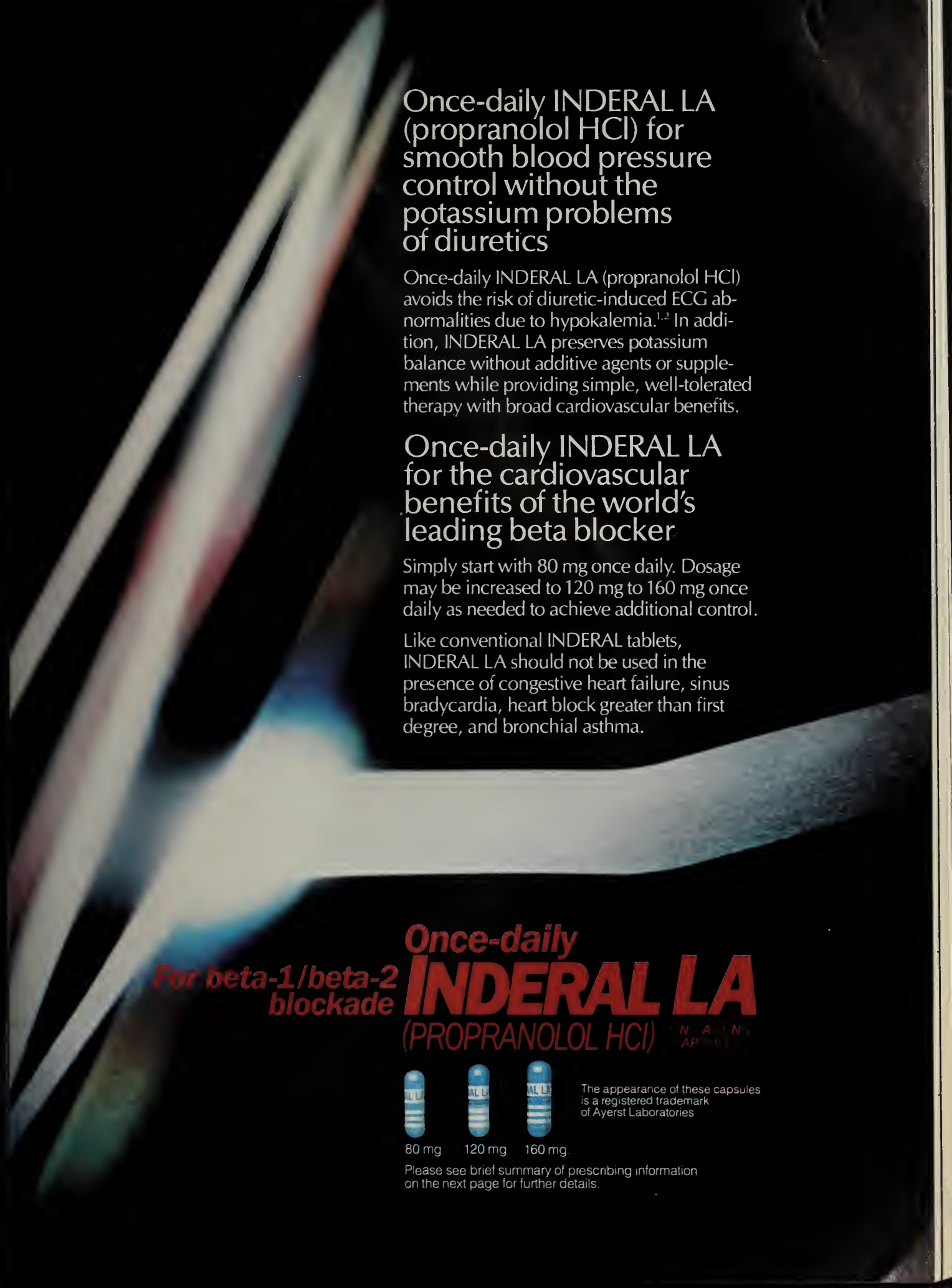
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J-4044 January 1984

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

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DESCRIPTION. Inderal LA is formulated to provide a sustained release of propranolol hydrochloride. Inderal LA is available as 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective beta-adrenergic receptor blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg for mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

The mechanism of the antihypertensive effect of INDERAL has not been established. Among the factors that may be involved in contributing to the antihypertensive action are (1) decreased cardiac output, (2) inhibition of renin release by the kidneys, and (3) diminution of tonic sympathetic nerve outflow from vasomotor centers in the brain. Although total peripheral resistance may increase initially, it readjusts to or below the pretreatment level with chronic use. Effects on plasma volume appear to be minor and somewhat variable. INDERAL has been shown to cause a small increase in serum potassium concentration when used in the treatment of hypertensive patients.

In angina pectoris, propranolol generally reduces the oxygen requirement of the heart at any given level of effort by blocking the catecholamine-induced increases in the heart rate, systolic blood pressure, and the velocity and extent of myocardial contraction. Propranolol may increase oxygen requirements by increasing left ventricular fiber length, end diastolic pressure and systolic ejection period. The net physiologic effect of beta-adrenergic blockade is usually advantageous and is manifested during exercise by delayed onset of pain and increased work capacity.

In dosages greater than required for beta blockade, INDERAL also exerts a quinidine-like or anesthetic-like membrane action which affects the cardiac action potential. The significance of the membrane action in the treatment of arrhythmias is uncertain.

The mechanism of the antimigraine effect of propranolol has not been established. Beta-adrenergic receptors have been demonstrated in the pial vessels of the brain.

Beta receptor blockade can be useful in conditions in which, because of pathologic or functional changes, sympathetic activity is detrimental to the patient. But there are also situations in which sympathetic stimulation is vital. For example, in patients with severely damaged hearts, adequate ventricular function is maintained by virtue of sympathetic drive which should be preserved. In the presence of AV block, greater than first degree, beta blockade may prevent the necessary facilitating effect of sympathetic activity on conduction. Beta blockade results in bronchial constriction by interfering with adrenergic bronchodilator activity which should be preserved in patients subject to bronchospasm.

Propranolol is not significantly dialyzable.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (e.g., chronic bronchitis, emphysema)— PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, e.g., dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. *General:* Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

Clinical Laboratory Tests: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

Pregnancy: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose. There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: bradycardia, congestive heart failure; intensification of AV block, hypotension, paresthesia of hands, thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL tablets to INDERAL LA capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg for mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three to seven day intervals until optimum response is obtained. Although individual patients may respond at any dosage level, the average optimum dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

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PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

REFERENCES

1. Holland OB, Nixon JV, Kuhnert L: Diuretic-induced ventricular ectopic activity. *Am J Med* 1981;70:762-768. **2.** Holme I, Helgeland A, Hjermann I, et al: Treatment of mild hypertension with diuretics. The importance of ECG abnormalities in the Oslo study and in MRFIT. *JAMA* 1984;251:1298-1299.

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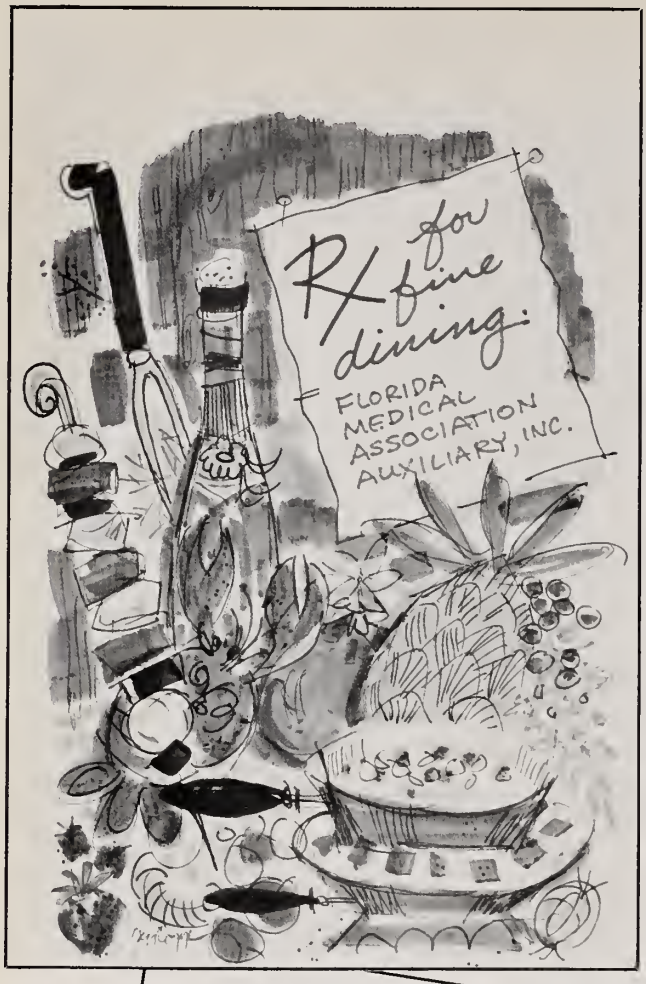
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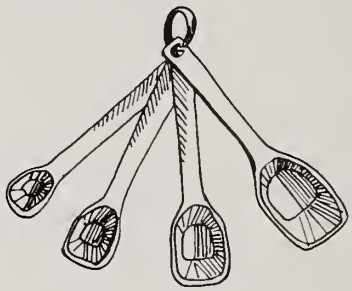
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1 can sweetened condensed milk
½ cup lime juice (4-6 limes)
*6 egg whites**
½ tsp. cream of tartar
¾ cup sugar
1 9" graham cracker pie shell, baked

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice; mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving.

*You can make the meringue with only 4 egg whites from the eggs you've used

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Auxiliary Liaison Editor — Mrs. Walter (Isabella) Laude

Reflections of an Auxiliary year

"To cultivate friendly relations and to promote mutual understanding among the families of medical doctors" is the first objective of the Florida Medical Association Auxiliary; and with the winds of change blowing in medicine's direction, this objective has become particularly significant.

The Auxiliary spent a great amount of time this year working on the Reason '84 campaign. It was a chance to put our resources, time and talents together to assist the FMA. While we felt really crushed when the initiative was struck down, we can also see that it had beneficial effects. It sparked a legislative interest that was only an ember into a full flame and activated members who had only been on the sidelines before.

For many years, the Auxiliary has placed community educational projects and philanthropic programs as the priority for growth. Today's medical spouse is besieged with requests to participate in a variety of worthwhile activities. And in order to grow as an Auxiliary, we have had to keep up-to-date on the needs of our state.

Even though we are the second largest state Auxiliary in the nation, we have unbelievable potential in membership.

This year we are very proud of our progress in the field of aging. The success of the Medi-File was due to the joint efforts of the Auxiliary and the FMA staff. The state aging chairman, public relations chairman and I attended the Governor's Commission on Aging meetings in Tallahassee, and from that are becoming active in working on Alzheimer's legislation.

It was a thrill for us to have Mrs. Adele Graham, the Governor's wife, making our public service announcements on the Medi-Files.

On a more personal level, I did not realize the enormity of being president of this multiphasic organization. I have loved the traveling around the state, meeting and working with Auxilians, having the honor of attending and reporting first hand to the FMA Board of Governors, and the opportunity of working with Dr. Frank Coleman.

There was so much to accomplish that the year just flew by and I am proud to report that the 1984-85 year was a year **IN ACTION.**

Mrs. Laurin G. Smith
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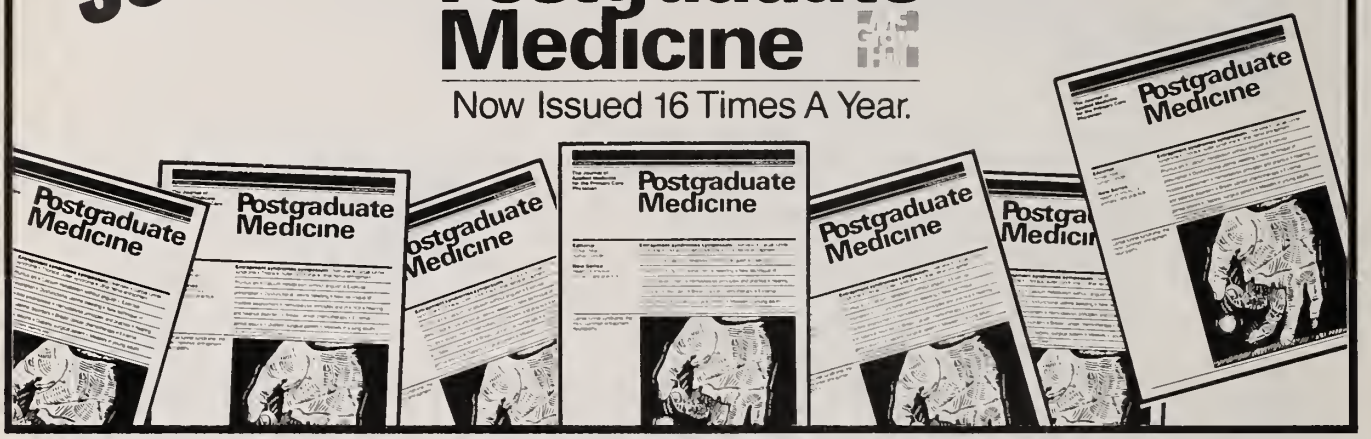
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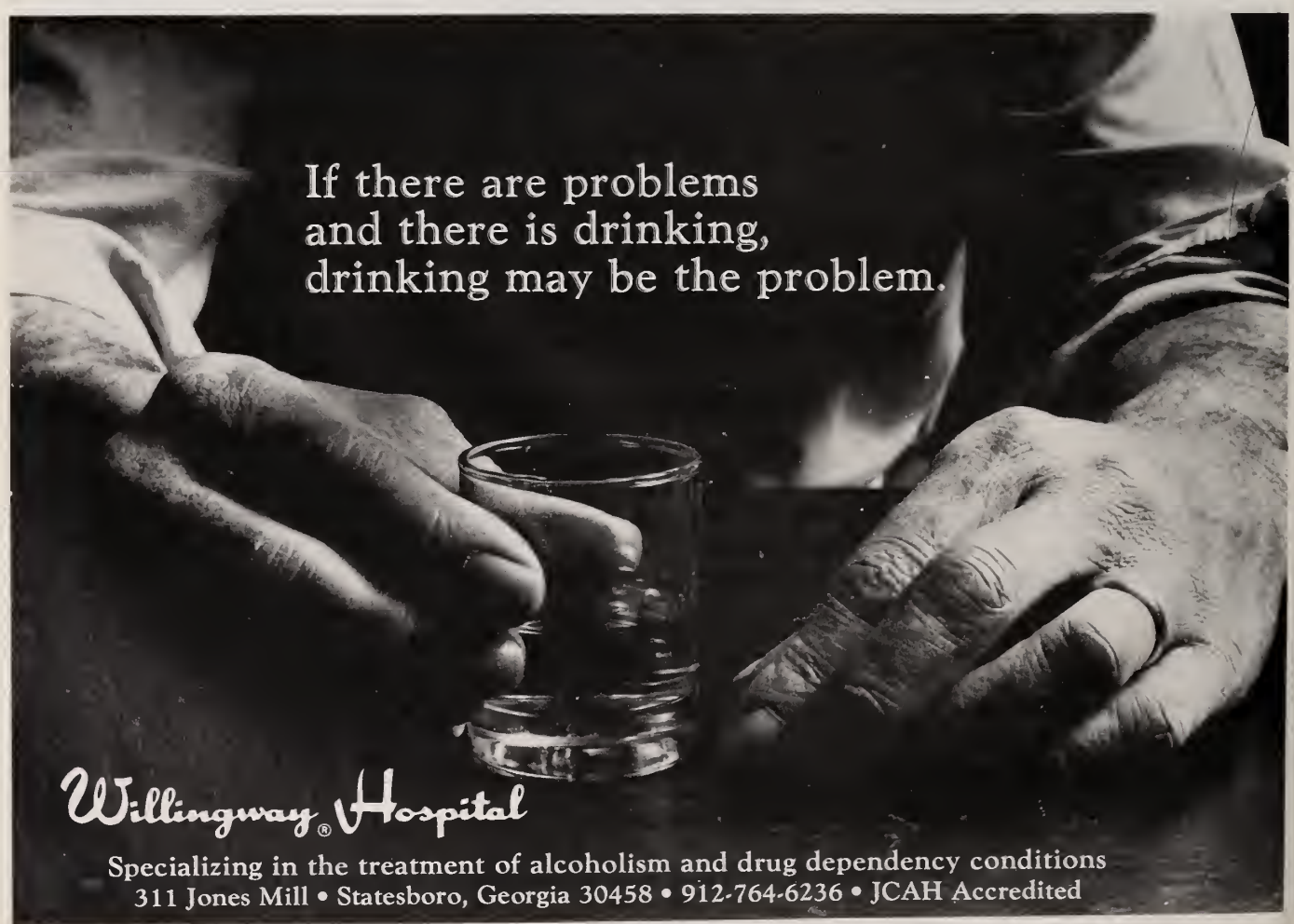
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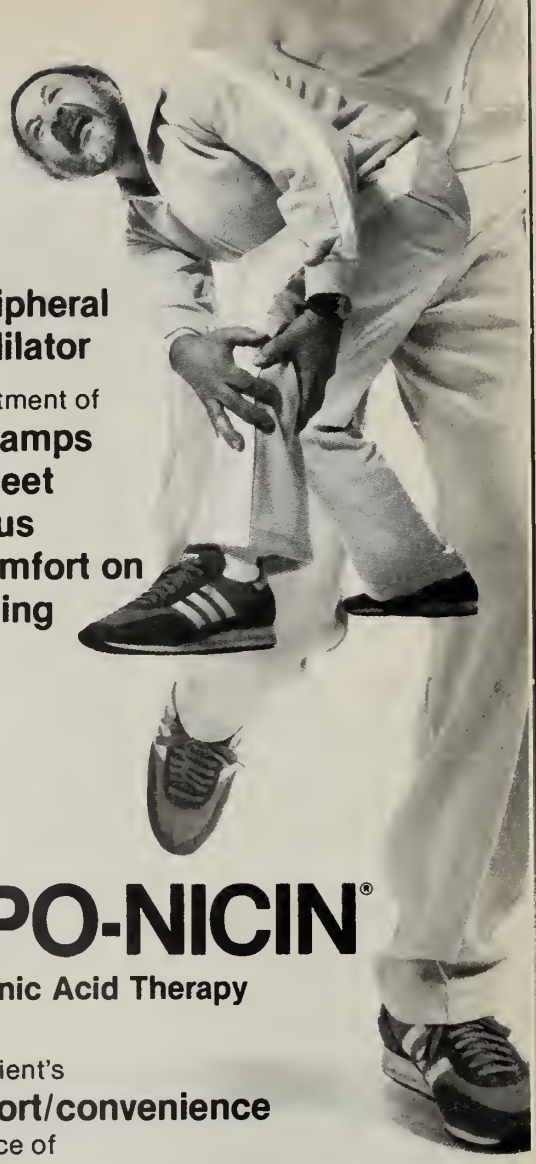
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Neonatal & Pediatric Respiratory Disease Conference, June 6-9, Sheraton-Sand Key Resort Hotel, Clearwater Beach. For information: Myrtle Larson, R.N., Gulf Coast Lung Assn., 6160 Central Ave., St. Petersburg 33707.

American & European Views on Critical Care, June 8-15, Cannes, France. For info.: Sonja Craythorne, Dept. of Anesthesiology, Univ. of Miami, Miami 33101, (305) 547-6411.

Coronary Artery Disease and Sudden Death: Primary and Secondary Prevention, June 14-16, Hyatt Grand Cypress, Orlando. For information: Margaret Kleiger, 64 Inverness Dr. E., Englewood, CO 80112, (303) 790-8445.

Emergency Care: The Pediatrician's Turf, June 15-19, Sheraton Sand Key Hotel, Miami. For info: Gilbert Pitisci, 2902 Beach Drive, Tampa 33609.

10th Annual Florida Suncoast Pediatric Conference, June 15-19, Sheraton Sand Key Hotel, Clearwater Beach. For information: Gilbert Pitisci, M.D., 2902 Beach Dr., Tampa 33609, (813) 870-3720.

Advances in Internal Medicine, June 23-28, France. For information: Div. of CME, P.O. Box 016960, Miami 33101, 315-547-6716.

JULY

Vascular and Pulmonary Disease: Diagnosis and Management, July 26-28, Orlando Hyatt, Kissimmee. For information: Stephen Mattingly, 5808 S. Rapp Street, Littleton, CO 80120, (303) 798-9682.

AUGUST

Controversies in Carcinoma of the Breast, August 7-10, Hyatt Regency Grand Cypress, Orlando. For info: Charleen Krissman, 12901 N. 30th St., Tampa 33612, (813) 974-2538.

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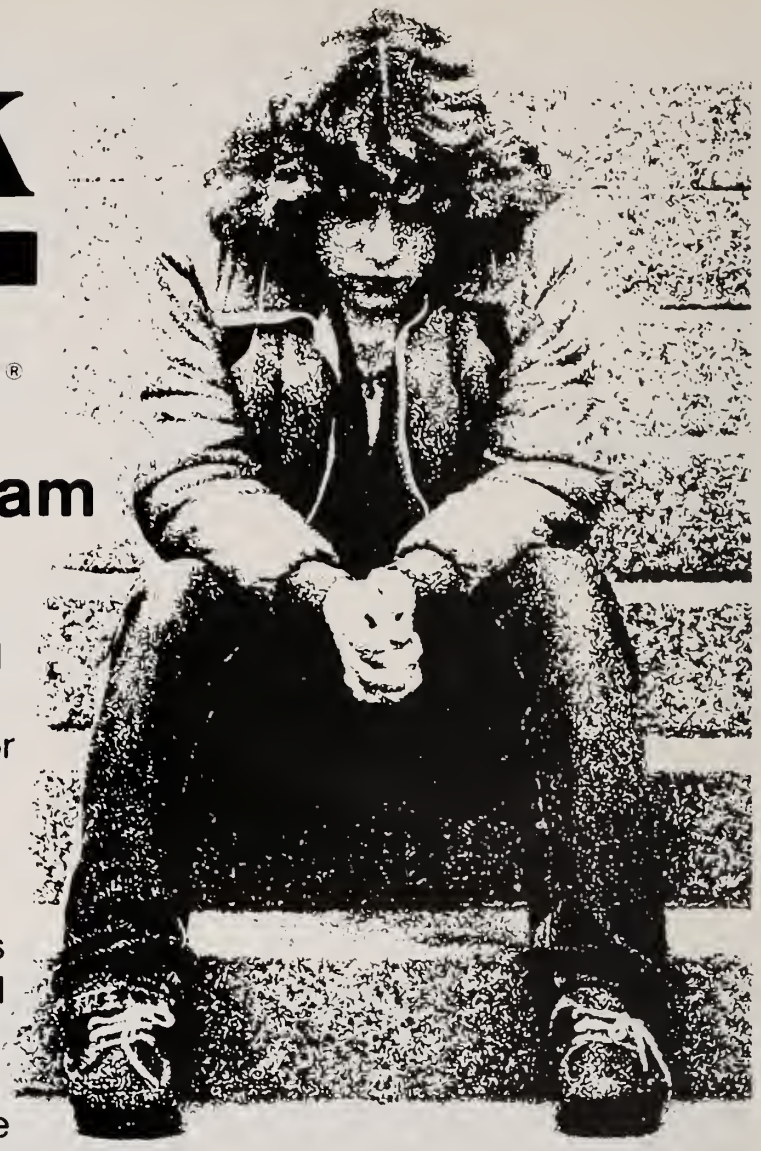
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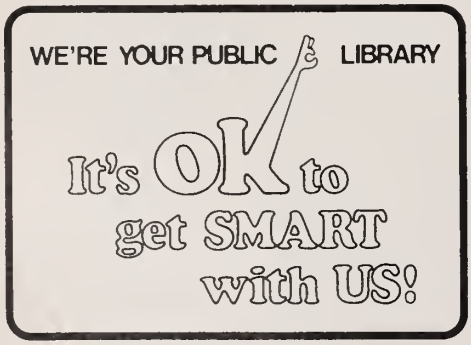
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Heart Healthy Recipe

CHILI SAUCE DIP

1	12-ounce bottle chili sauce
2	tablespoons lemon juice
3-4	drops tabasco sauce
2	tablespoons horseradish
¼	cup finely chopped celery
1	tablespoon minced parsley

Combine all ingredients and chill. Serve with crisp raw vegetables.
Yield: about 1½ cups
Approx. cal/serv.: 1 tablespoon = 5

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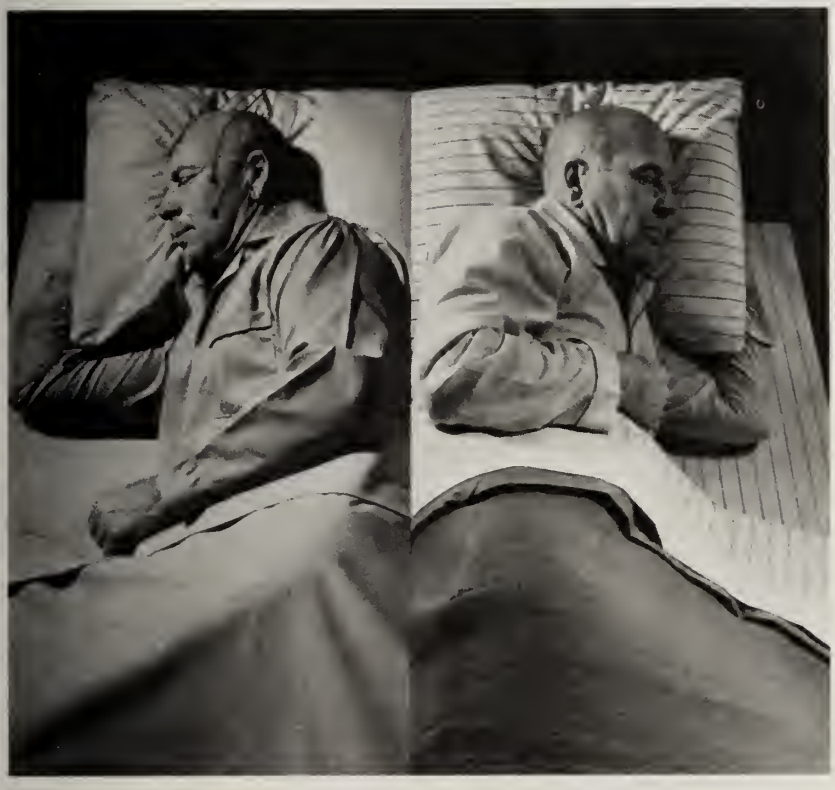
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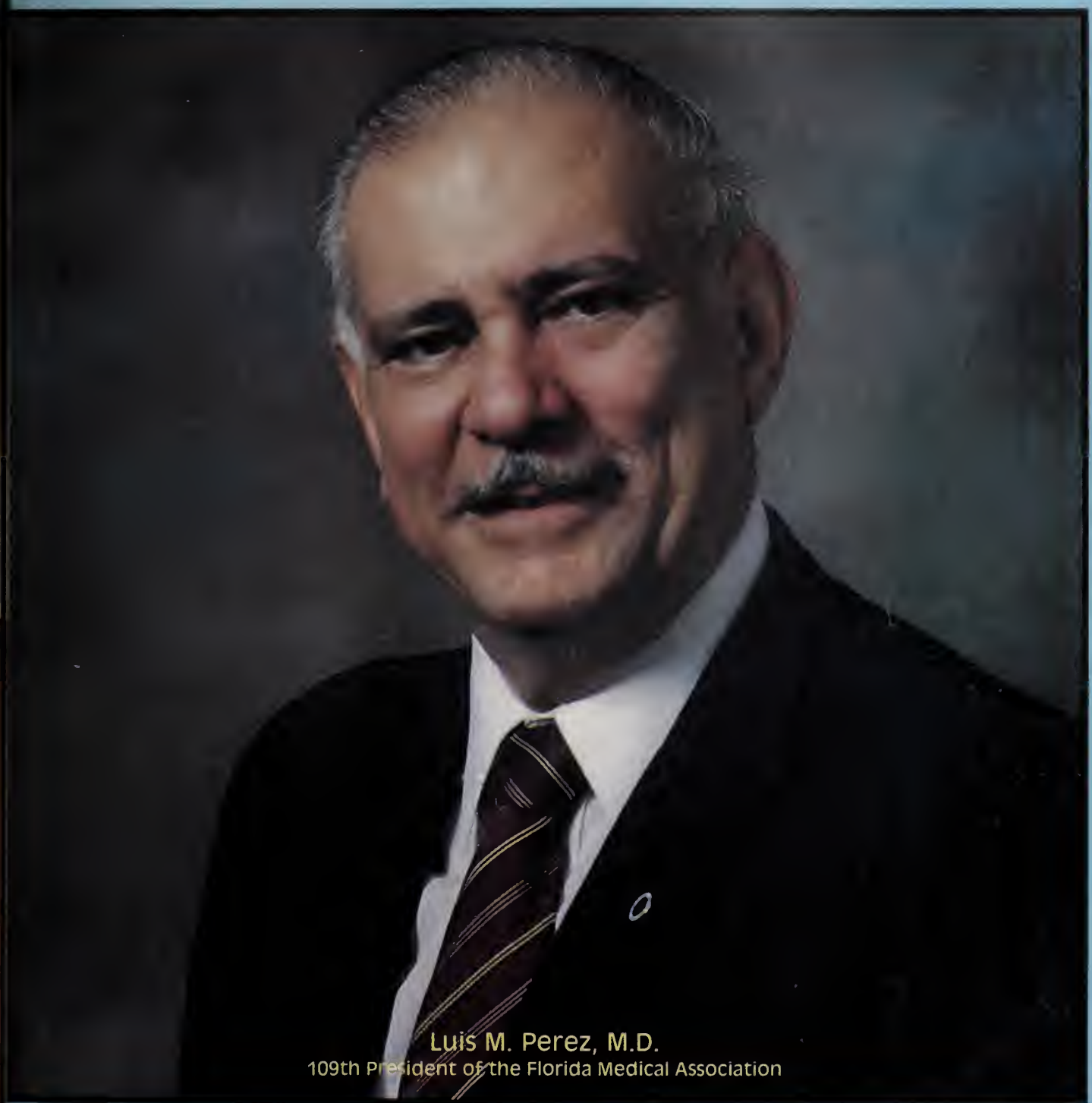
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Contraindications: Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum K^+ levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **Associated widened QRS complex or arrhythmia requires prompt additional therapy.** Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

Precautions: The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of Dyrenium (triamterene, SK&F CO.) and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function.

Thiazides may add to or potentiate the action of other antihypertensive drugs.

Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

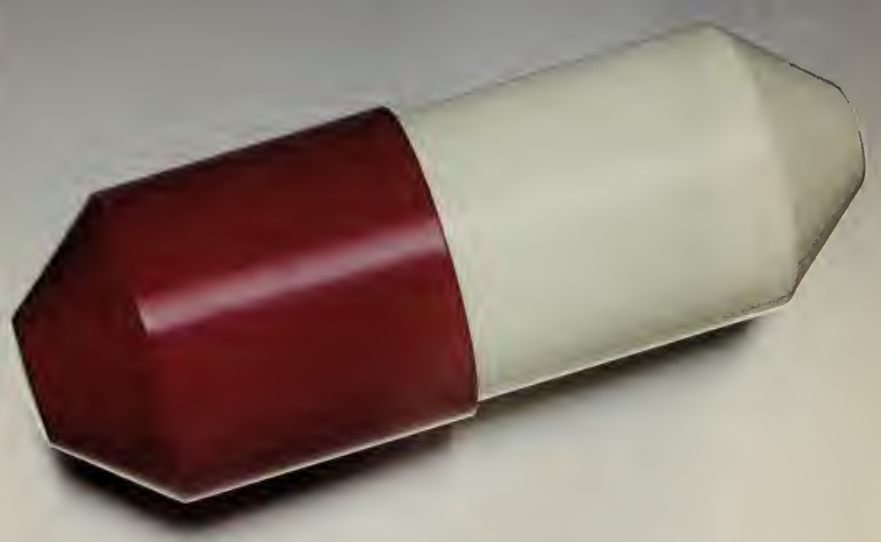
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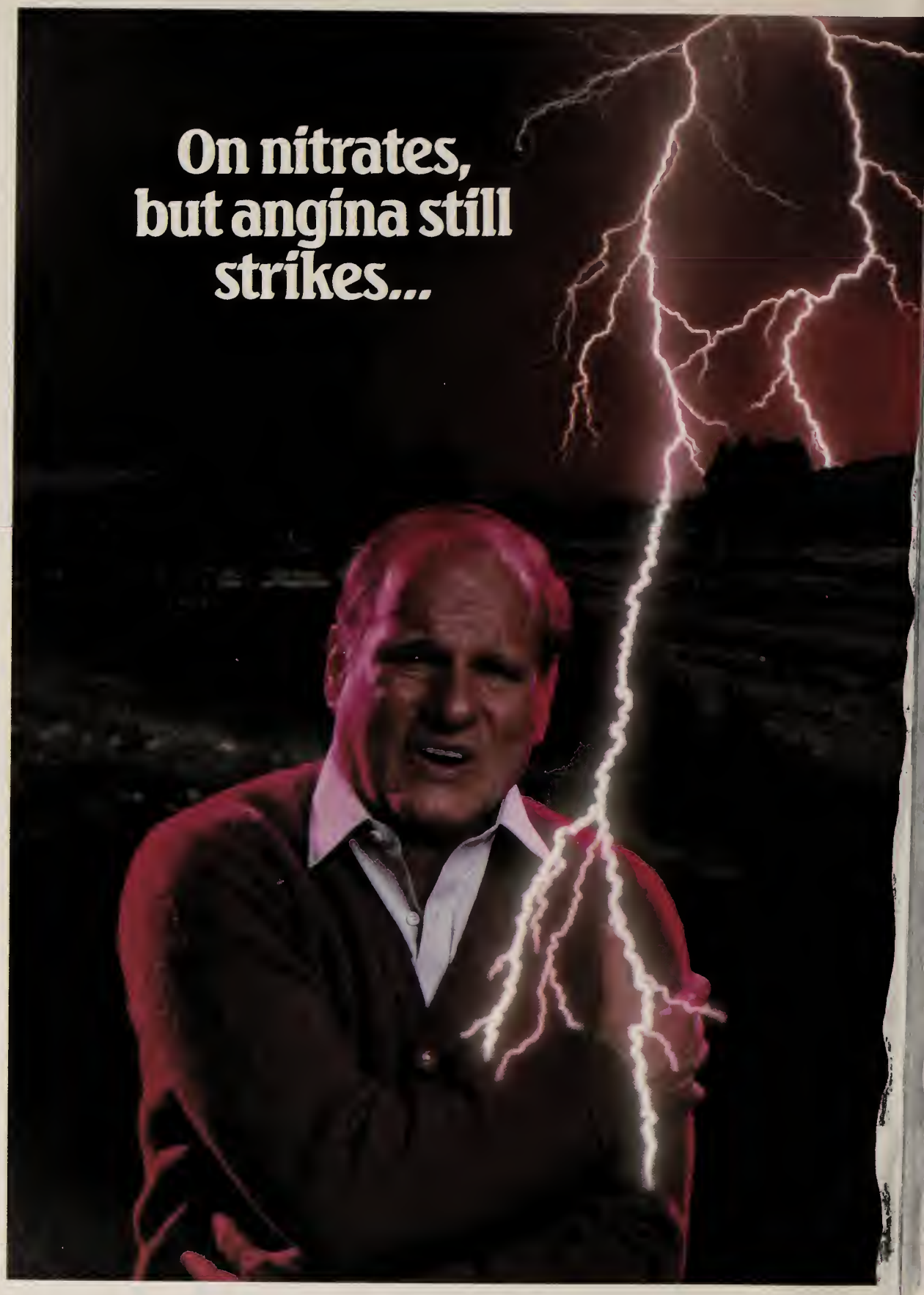


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Contraindications: Severe left ventricular dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (except in patients with a functioning artificial ventricular pacemaker), 2nd- or 3rd-degree AV block. **Warnings:** ISOPTIN should be avoided in patients with severe left ventricular dysfunction (e.g., ejection fraction < 30% or moderate to severe symptoms of cardiac failure) and in patients with any degree of ventricular dysfunction if they are receiving a beta blocker. (See *Precautions.*) Patients with milder ventricular dysfunction should, if possible, be controlled with optimum doses of digitalis and/or diuretics before ISOPTIN is used. (Note interactions with digoxin under *Precautions.*) ISOPTIN may occasionally produce hypotension (usually asymptomatic, orthostatic, mild and controlled by decrease in ISOPTIN dose). Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment, however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. Chronic ISOPTIN treatment increases serum digoxin levels by 50% to 70% during the first week of therapy, which can result in digitalis toxicity. The digoxin dose should be reduced when ISOPTIN is given, and the patients should be carefully monitored to avoid over- or under-digitalization. ISOPTIN may have an additive effect on lowering blood pressure in patients receiving oral antihypertensive agents. Disopyramide should not be given within 48 hours before or 24 hours after ISOPTIN administration. Until further data are obtained, combined ISOPTIN and quinidine therapy in patients with hypertrophic cardiomyopathy should probably be avoided, since significant hypotension may result. Clinical experience with the concomitant use of ISOPTIN and short- and long-acting nitrates suggest beneficial interaction without undesirable drug interactions. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. *Pregnancy Category C*: There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor and delivery only if clearly needed. It is not known whether verapamil is excreted in breast milk; therefore, nursing should be discontinued during ISOPTIN use. **Adverse Reactions:** Hypotension (2.9%), peripheral edema (1.7%), AV block: 3rd degree (0.8%), bradycardia: HR < 50/min (1.1%), CHF or pulmonary edema (0.9%), dizziness (3.6%), headache (1.8%), fatigue (1.1%), constipation (6.3%), nausea (1.6%), elevations of liver enzymes have been reported. (See *Warnings*.) The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984 2385

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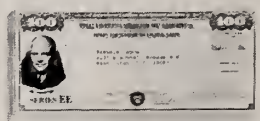


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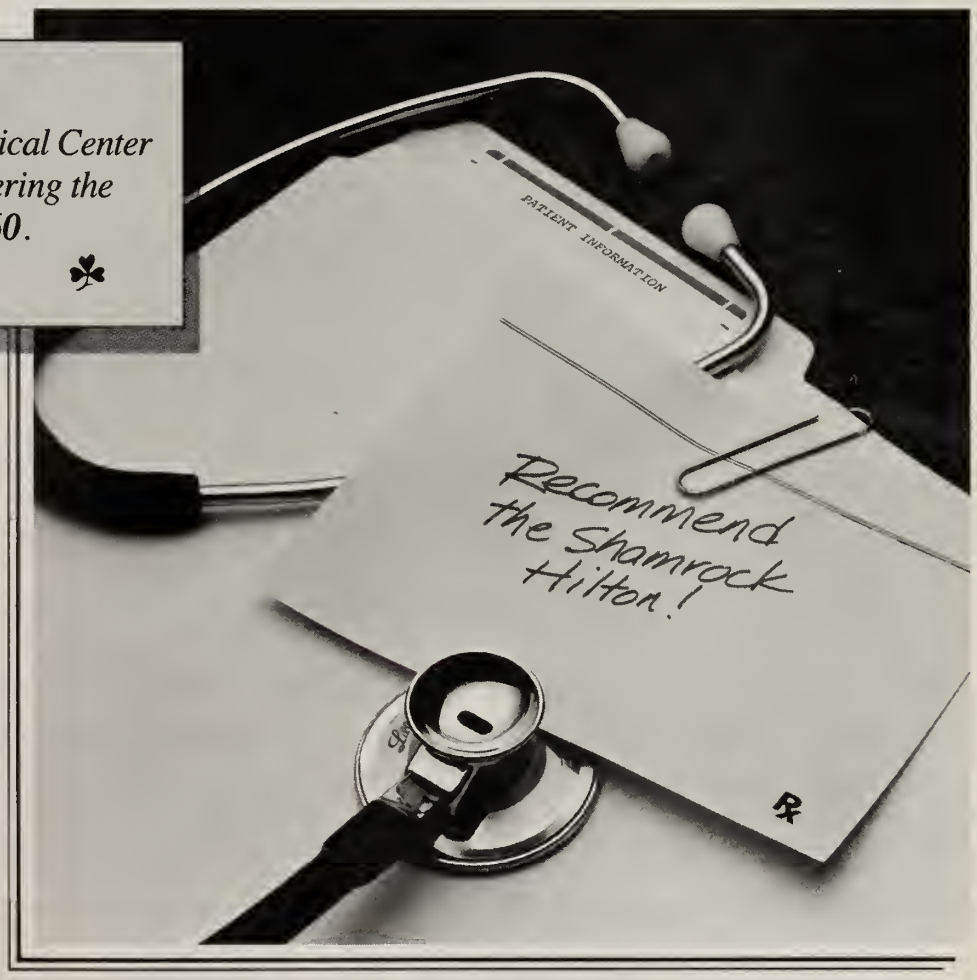
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COVER

Luis M. Perez, M.D., was installed in Hollywood on May 5, 1985, as the 109th President of the Florida Medical Association. President Perez is an internist in Sanford.

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Working for unity and a new beginning



In the life of every person there are events that produce a change of direction, and even though it may not be known at that moment, these events may change one's life. Taking office as your President is the culmination of a dream and new direction in my life.

Last year was a very difficult and challenging one for our Association, and even though we have made tremendous strides forward, I know very well this year is not going to be a rose garden. It will require a constant effort from the ones who represent you at the local, state and national level because the surmounting difficulties that lie ahead for the practice of medicine are many and uncertain.

At the state level, the Florida Legislature has passed a bill which takes a step toward resolution of the malpractice crisis.

We are encouraged that the Legislature has recognized the gravity of the crisis in our state. They have worked diligently to put forth, in the best interests of the citizens of Florida, a bill which should rectify some areas of the problem which are having such adverse effects on the cost, quality and access to health care in our state. Although the bill does not offer a complete solution, we are hopeful the improvements enacted will provide some relief for Florida citizens. However, a permanent solution to the problem will be unlikely as long as medical malpractice cases are handled in the current tort system.

Improvements to the current system provided for in the bill include: a community standard of care which will allow juries to consider all relevant circumstances surrounding an alleged action of malpractice; structured payments on all future damages above $500,000, which will ensure that the injured party will have a continuing source of future income to pay their living and health care expenses; increased protection for peer review activities; a new offer of judgment statute which should help encourage settlements; a new 90-day cooling off statute, coupled with non-binding arbitration when appropriate, which should help resolve cases without lengthy and expensive trials; a sliding scale for lawyer's contingency fees which should put more money into the hands of injured parties; and a study of risk management programs to determine what effect they have on medical malpractice claims.

The bill also will require mandatory professional liability insurance as a condition for licensure effective January 1, 1987. Current rates could make this provision prohibitively expensive for some high risk specialties. However, since this requirement will not take effect until January 1, 1987 and will be evaluated by a study committee established by the bill, there should be sufficient time to determine whether mandatory insurance in fact will be helpful and feasible in today's volatile litigious climate. Our actuarial and legal consultants will study all the provisions of the final bill in order to determine the real effect this bill may have on resolving the medical malpractice problem, including continuingly escalating professional liability insurance premiums and health care costs for Florida citizens. Based upon this evaluation, the FMA will be prepared to take the initiative in developing additional reforms which may be necessary to bring about a permanent solution.

The issue of non-physician providers, which keeps raising its ugly head year after year, threatens

the quality of medical care to the citizens of our state and increases the liability issue to the physicians on hospital staffs, the physicians that oversee these individuals, and the hospitals themselves.

The drug abuse problem among our youngsters and middle age population continues to be an increasing problem in our society with its logical consequences in health care for these individuals. We should address this problem and offer guidance and education.

The young physicians, fresh out of their residency, face a serious problem. Pressed by debts from medical school and training years, they come into a new environment with very little guidance in how to manage. They face offers from entrepreneurs who run a gamut of health services which are very tempting as a fast solution. Without having the insight of what it means to their future, they are lured into these types of organizations. We are giving guidance and orientation to young physicians preserving the individuality and independence of the medical practice.

The increasing problems of quality of care at HMOs, IPAs, PPOs, etc., the overutilization and exploitation of the health insurance companies' benefits, abuse to patients at some ambulatory clinics, the so-called emergency or surgical medical centers, and a few individual practitioners must be controlled in some manner. The Florida Medical Association has a moral and ethical duty to find the way to do so.

Issues of concern at the national level are: the spectrum of DRGs for physicians in hospital practices with all the complications this will bring; the freezes on Medicare with increases in deductibles that penalize hospitals, physicians, and the elderly population, which is increasing in our state; cuts in educational and research funds with a terrible implication for the physicians and the health of the nation in the long run; and the emphasis of Federal Government on economy, divorced from quality of care with its logical consequences, that will bring about patient suffering and increases in liability. These are a few, but certainly not all of the issues we will be facing.

What are we to do next? In which direction shall we go to curtail, or at least ameliorate this trend? What kind of guidance must we offer the physicians of Florida, and the public whose health and well being are our utmost responsibility?

First, we are going to continue our efforts this year in legislation to affect the necessary changes in order to diminish the professional liability problems and the situation with non-physician providers. At the same time we are going to start an aggressive public education program guided by professional public relations individuals to enhance the image of the physician and the benefits of the private practice of medicine, emphasizing the quality of care and all the attempts to diminish it for purely unfounded economical reasons.

We are also continuing to build bridges and form a liaison with other groups vitally interested in professional liability and quality of care at an affordable price, in order to form a solid front with a clear understanding of the direction we are going, since there is a possibility, in 1986, that we must appeal to the public with another constitutional amendment on the professional liability issue.

At the national level, our AMA Florida delegation, more and more influential as we grow larger and more experienced under the leadership of Charles Donegan, M.D., and Joseph Von Thron, M.D., and the national legislative committee of our Association with Louis Murray, M.D., as Chairman, will coordinate efforts with the AMA to emphasize our views and how these policies affect our state and the nation in general.

The work ahead will not to be easy. The Executive Committee of your Association and the members of the Board of Governors have the responsibility to keep the line of communications open with the local medical societies in their district, and with medical staffs in hospitals from the area they represent. I appeal to all of you, to keep abreast of the issues and utilize every staff meeting, specialty meeting and medical society meeting that you attend to keep everyone informed of our activities and efforts.

There have been serious problems with communications in the past, but not due to a lack of attempts to communicate. We have received recently innumerable President's Memos, which kept us informed of each problem. In every issue of *The Journal*, the President's Page, news of all the activities of the Association has been published. However, when we visited several local medical societies we were asked questions on basic issues clearly stated in these publications, because the average physician does not take a few minutes to read our communications.

Communication will be one of our principal goals. We need to educate our members to realize that this Association and the AMA are vital to their professional careers, and even though the practice of medicine will never be as it was 10 years ago, we and only we, can influence the direction in which it is going.

Recognizing this, we must develop a tighter society, a unity of direction, a better knowledge of the issues and the political realities of our times; be ready to be counted, to offer imaginative and novel solutions to the problems that face us, altering, modifying, changing concepts in the minds of the public at large. We must expose the proposals of our adversaries who are working diligently at the federal level with the purpose of creating a socialistic type of medical services throughout the nation, and show

those who try to maintain chaos and confusion among us that they cannot reap, in the courts of law, the benefits that create their wealth, at our expense and that of our patients.

These are the reasons the theme for this year is UNITY. We must regroup and take the offensive. For too many years we have been coping with problems as they have been presented to us, and we have been on the defensive. But we have observed the process, we have analyzed, one by one our defeats, and we have learned. We have dissected layer by layer each one of the processes in which we have been entangled and we have learned and continue to learn.

Now we know our weaknesses and our strengths. We also know that if we close the ranks, we will produce the necessary unity for our efforts to culminate. If we take the offensive instead of the defensive position, our efforts will fructify and our profession will remain one of honor and distinction, respected and admired by all, for the benefit of the health of the people of our state and an example to the nation.



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4. Clinical Use of Electronic Infrared Thermography in Orthopedic Practice — Joseph Uricchio, M.D.*, Orthopedic Surgeon, Orlando, Florida.

5. Thermographic Report Writing — Dr. Alan Weinstein, D.O.*, Physiatrist, Old Bridge, New Jersey.

6. Use of Electronic Thermography in Sports Medicine — James Maultsby, M.D.*, Orthopedic Surgeon, Greensboro, North Carolina.

7. Use of Electronic Thermography in Disability Evaluations and Medico-Legal Work Up — Joseph Uricchio, M.D.*

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Luis M. Perez, M.D.
109th President
Florida Medical Association

Luis M. Perez, M.D.

The inauguration on May 5, 1985, of Luis M. Perez, M.D., as president of the Florida Medical Association was a proud moment in its history.

Born and raised in Cuba, Dr. Perez graduated from the College of Medicine, Havana University. Shortly after the revolution and the ascendancy to power of the communist regime, Dr. Perez's strong dedication to freedom and independence resulted in his coming to the United States where he took up and completed his internship and residency in internal medicine and cardiology at Georgia Baptist Hospital, Atlanta. He entered the private practice of internal medicine and cardiology in Sanford, Florida, in 1963, where he has practiced since.

While pursuing an active medical practice in association with Maria Perez, M.D., his wife and a dermatologist, Luis rapidly gave of his time and energies to the cause of organized medicine and community affairs. His zeal, enthusiasm and talents were quickly recognized by the individuals and groups with which he associated. He has served as Chief of Staff of Seminole Memorial Hospital. His representation of Seminole County Medical Society as a delegate to FMA dates back to 1969. AMA tenure includes service as alternate delegate, 1980, and delegate since 1981. Dr. Perez's qualities of leadership and diplomacy were quickly recognized by the FMA where he has served on many committees and councils and on the Board of Governors since 1981 as Secretary and as President-Elect this past year.

Dr. Perez has not confined his activities to organized medicine, but has an enviable record of service and accomplishment in the area of community affairs. These activities involve membership on the Civil Service Board of Sanford, from 1968 to the present, chairmanship of the Board of the Migrant Clinic Association of Seminole County, membership on the United States Congressional Advisory Board, and founding and charter membership of Seminole County Drug Action Committee, as well as founding of "The Grove" rehabilitation center for drug abuse. Dr. Perez has been an active member of the Greater Sanford Chamber of Commerce as well as participating in many speakers' forums on items of community concern.

His awards are numerous and far-reaching, including the 1968 Citation for Outstanding Service in the Stimulation of Better Citizenship, the A.H. Robbins Award for Citizenship and Community Service 1971, International Human Relations Award by the Dale Carnegie Alumni Association, The George Washington Medal of Honor from the Freedom Foundation at Valley Forge 1973, and the Benjamin Rush Award of the AMA.

Dr. Perez has the loving support of his wife, Maria Perez, M.D., and his two sons, Luis, Jr., who is pursuing a successful theatrical career, and Tico, who is currently enrolled as a student in the Georgetown College of Law in Washington, D.C. The challenge of overcoming adversities is not new to Dr. Perez, a man whose abilities, determination, and honor brought him out of the ashes of the catastrophe of communism that engulfed his native land of Cuba, into this free land of ours to which he has supplied his energies, intelligence, and leadership qualities to the benefit of us all.

At a time when private practice of medicine is beset by challenges from all quarters including the professional liability crisis, the intrusion of paramedical groups into the practice of medicine, the problems involved with foreign medical graduates, the ever present escalating involvment of federal and state governmental leaders and legislative bodies

in the doctor-patient relationship, we are indeed fortunate to have such a symbol of leadership and strength at the helm as Dr. Luis M. Perez. His vast experience and depth in facing such challenges will enable us to achieve our goals.

To solve our problems we need this strong and able leadership, and in Luis Perez we have this leadership. All of his awards and accomplishments only indicate the powers of this man, the man we have confidence in to guide us through the challenges of the year ahead. He is indeed a man for our time with the talent, dedication, and diplomacy to make this coming year a successful one for the Florida Medical Association.

Louis C. Murray, M.D.
Orlando

Remigio G. Lacsamana, M.D., new editor of the JFMA

May 1, 1985, marked the beginning of a new era for *The Journal of the Florida Medical Association*. As has been the policy of the past, the editor of *The Journal* may serve up to a five-year period. Daniel Nunn, M.D., from Jacksonville, has completed his current term, and Remigio C. Lacsamana, M.D., from Volusia County, has become the new editor of *The Journal*.



Dr. Lacsamana

Dr. Lacsamana is a native of the Philippines, and came to the United States in 1964, one year after graduating from medical school. His writing experience began early in his college career at the University of Santo Tomas in Manila where he was sports editor and, later, assistant editor of the student publication. Dr. Lacsamana currently practices internal medicine in Daytona Beach. He has been active in the community, as well as in the Volusia County Medical Society, since his arrival.

Early in his tenure on the Executive Committee of the Volusia County Medical Society, Dr. Lacsamana noted that *The Stethoscope*, the official publication of the Volusia County Medical Society, had been dormant for several years. He requested that the Executive Committee reactivate publication of *The Stethoscope* and volunteered his services as editor. *The Stethoscope* was again published in December of 1980, and in 1982, 1983, and 1985 was awarded first prize for General Excellence in the Annual Journal of the Florida Medical Association Awards Contest for county medical society bulletins. Dr. Lacsamana won a first place award for Best Editorial in 1983 for his article on "The Changing Medical Image." In 1984 *The Stethoscope* also received a special citation for general excellence at the annual FMA meeting.

In October, 1983, Dr. Lacsamana was appointed Assistant Editor of *The Journal of the Florida Medical Association*. His contributions to this point have been outstanding. I have had the pleasure of knowing Remy Lacsamana for the past fifteen years. Having read his editorials in *The Stethoscope*, and in talking with him personally, I feel that he is an intelligent, and articulate person who also expresses himself in writing with clarity and alacrity. In the next five years, Florida Medical Association members will become familiar with Remy's literary talents and, in my opinion, the excellence that *The Journal of the Florida Medical Association* has enjoyed over the past years will be continued under his very capable leadership. It is with great pleasure that I have the opportunity to introduce you to this outstanding physician and very personable human being.

James G. White, M.D.
Daytona Beach

Reflections on a new season

The editorship of *The Journal of the Florida Medical Association, Inc.* changes hands with this issue. Daniel B. Nunn, M.D., the editor for the past five years, has completed his term after steering *The Journal* to new heights of excellence. The responsibility now falls on me, as the new editor, to continue the job and to maintain *The Journal's* tradition of excellence.

Editing the JFMA will be a great challenge, more so with the knowledge that it was named the best state medical journal in 1983 at the Annual Sandoz contest. That is quite a distinction, and henceforth will be a yardstick against which judgments on the quality and excellence of *The Journal* will be made in the future. In many ways, the achievement should spur the current editorial staff to rise to the occasion and to continue to produce a medical journal of which members of the FMA should be proud.

The transition from one editor to another is an auspicious occasion for the new editor to announce his philosophy, plans, and changes, if any, for *The Journal*. I shall exercise that prerogative.

The basic philosophy of the *JFMA* will remain the same. As the official mouthpiece of the FMA, *The Journal* will continue to be an active instrument to promote the interests of the medical association and its members, to advocate its policies and stands on various issues, to serve as a repository for its proceedings, to disseminate scientific and other types of information, and to serve as a forum for debates, discussions, and exchange of ideas among FMA members. The basic format will also be retained, with a few forthcoming changes which are being planned to broaden further the appeal of *The Journal* to its readers and to accomodate the far-flung and eclectic interests now within the compass of medicine. Medicine, after all, has changed drastically, and *The Journal* needs to mirror these changes.

One plan being considered is an increase in the editorial coverage of the broad spectrum of issues and subjects now facing physicians. The astounding flurry of developments in medicine today makes this necessary. Informed comments, judgments, editorials, opinions, points, and counterpoints from the editorial staff, FMA officers, and members of the medical association will be basic staples in future issues. Physicians need to be well informed not only about medicine, but about other issues as well impinging on the practice of medicine today. In getting physicians immersed in this crucible of issues, *The Journal* hopes to contribute towards a more enlightened citizenry among members of the FMA.

Along with this, plans are afoot to broaden the news coverage of people and events shaping the course of medicine in Florida. There are many such items needing statewide exposure which should appeal equally well to physicians in Bunnel and to those in Miami. Who among us, for example, are familiar with Edward Annis, M.D., and the remarkable work that he has done for American medicine the last twenty years? How many of us have heard of the Mini-Internship Program except in the few counties like Alachua and Volusia where it has been successfully launched? The program has been lauded by the press, the public, and physicians as one of the most successful public relations efforts ever put forth by the medical profession; giving it more exposure perhaps will stimulate other county medical societies to do the same. *The Journal* will welcome contributions along this line from county medical

societies, and will accomodate them subject only to space limitations.

Another forthcoming change is the appearance of a section on medical economics, which is taking its bow in this issue. Whether we like it or not, medical economics has become entwined with the practice of medicine, and the physician who ignores it will do so only at his own risk. The section will explore the wide array of economic issues confronting the medical profession and, in so doing, enlighten physicians and perhaps guide them in making decisions. The section will have its own editor and will have the backing of the FMA Council on Medical Economics.

Expansion is also being planned for the Book Review section which has been intermittently limping for the past few issues. Books, whether medical or non-medical, should be an integral part of every physician's career; they constantly challenge and stimulate the mind and the heart, and serve to remind the physician that he is not only a scientist, but a cultured and broadly educated person who should be well versed in other human disciplines. Our Book Review editor, F. Norman Vickers, M.D., is a polymath, and he along with his coterie of reviewers will start offering in future issues a more palatable mixture of reviews designed to curb the common post-medical school anorexia and to stimulate the intellectual appetite.

Lastly, a new feature is being planned which will serve as a special forum for physicians to speak out on the burning medical issues of the day, similar in format to the popular Op-Ed page appearing in many national newspapers. This will complement the editorial pages and hopefully will stir physicians to write and tell their colleagues what they think about on any number of things. There are many subjects waiting to be tapped like trial lawyers, bumbling government bureaucrats, HMOs, the doctor glut, frozen fees, and artificial hearts; let us start the ball rolling and hear from *The Journal* readers.

Further changes and new features in the future of course will be dictated by changing developments in medicine and by the needs of the *JFMA* readers.

In the process of editing a publication like the *JFMA*, I must stress the point that the ultimate success of *The Journal* will depend on the capabilities of that cast of characters known as the editorial staff. I am happy to announce that I have assembled what I feel to be a talented team of editors, many of them veterans of *The Journal* editorial staff, and others who will be new faces but excellent writers, including the new editors of the Historical and Medical Economics sections. There will be a new category called "Contributing Editors," many of them well-known physicians in Florida, and they will complement the talents of our staff. Robert Fore, Ed.D., Sissy Crabtree, and Mary Fouraker will continue to provide us with excellent editorial help. It shall be my policy that every name that appears on the editorial masthead will contribute to the production of *The Journal*; this can only add to the vitality of the publication.

If we continue to produce a journal that is worthy of the FMA and its members, then we know we are doing our job well. If, on the other hand, *The Journal* is not meeting the expectations of its readers, please let us know. We will try as best as we can to give you a product that is at least as good as it was in the past, maybe even a tad better.

R. G. Lacsamana, M.D.
Editor
The Journal of the Florida Medical Association, Inc.

Governor's plan addresses health

In the comprehensive *State Plan* presented by Gov. Bob Graham to the 1985 Florida Legislature, item 28 lists the following goal for medicine: "By 1995, Florida will have a health care cost inflation rate no higher than that of inflation in general, without diminishing the quality of health care."

Prior to presentation to the legislature, this 30-item plan was developed by the various agencies of the Florida state government and submitted to panels of citizens all over the state for their comments and input. The plan attempts to address all areas of life in this state that are expected to be impacted by the phenomenal growth predicted for the next 15 years. It further attempts to pinpoint important issues to be addressed and specific measures which may be used to resolve those issues in each area of concern. The issue raised regarding health care is: "How can the State ensure access to high quality health care for all of its citizens and reduce the rate of increase in health care costs?"

To address that issue, the Governor's plan suggests fourteen specific policies as the guidelines for the State's agencies and for local governments and the business community. In general those policies aim toward increased health awareness and education, increased emphasis on disease prevention or treatment of earlier illness to avoid more expensive end-stage disease, increased utilization of pre-paid plans of medical care, and increased competition and cost conciousness among consumers, providers, and insurers. In addition, the problems of long-term care, environmental safety, and cost-shifting to fund indigent care are addressed.

Generally, this portion of the *State Plan* is one with which the physicians of Florida can and should agree. Gov. Graham has listened to the input of Florida's physicians in the past, and while he cannot be said to be in complete agreement with our profession on many issues, he has certainly helped us on several occassions in thwarting some very misguided programs approved by the Legislature. There can be no doubt that the State of Florida, like government at all levels, faces a substantial danger of runaway inflation in health care costs when one reviews the history of such costs in recent years. We must be concerned that such a runaway does not occur — both as a matter of concern for our patients and because we too are health care consumers as well as providers. Many of us continue to have strong doubts about the ability of HMOs, PPOs, etc. to be a panacea for such problems, but there is no longer any question as to whether such programs will be tried extensively and it is no surprise that the State will take an active part in such endeavors.

The goals and policies of the Plan are, therefore, reasonable. The desire to avoid "diminishing the quality of health care" in the process is heartening. It would thus appear that the challenge to Florida's physicians is to see that the interpretation of those policies in the coming years is true to the initial goals.

The danger of such straying is evident even in the proposed plan itself. In the "background" portion of item 28 of the Plan it is said that "In 1984 the Florida Legislature passed innovative legislation. . . providing financing for the health care of the poor." This, of course, refers to the charge assessed to all hospitals in the state as a percent of their revenues — the vast majority of which comes from paying patients. In proposed policy E36, however, the Plan states a desire to "Avoid the unregulated shifting of costs for treatment of indigent patients to other pa-

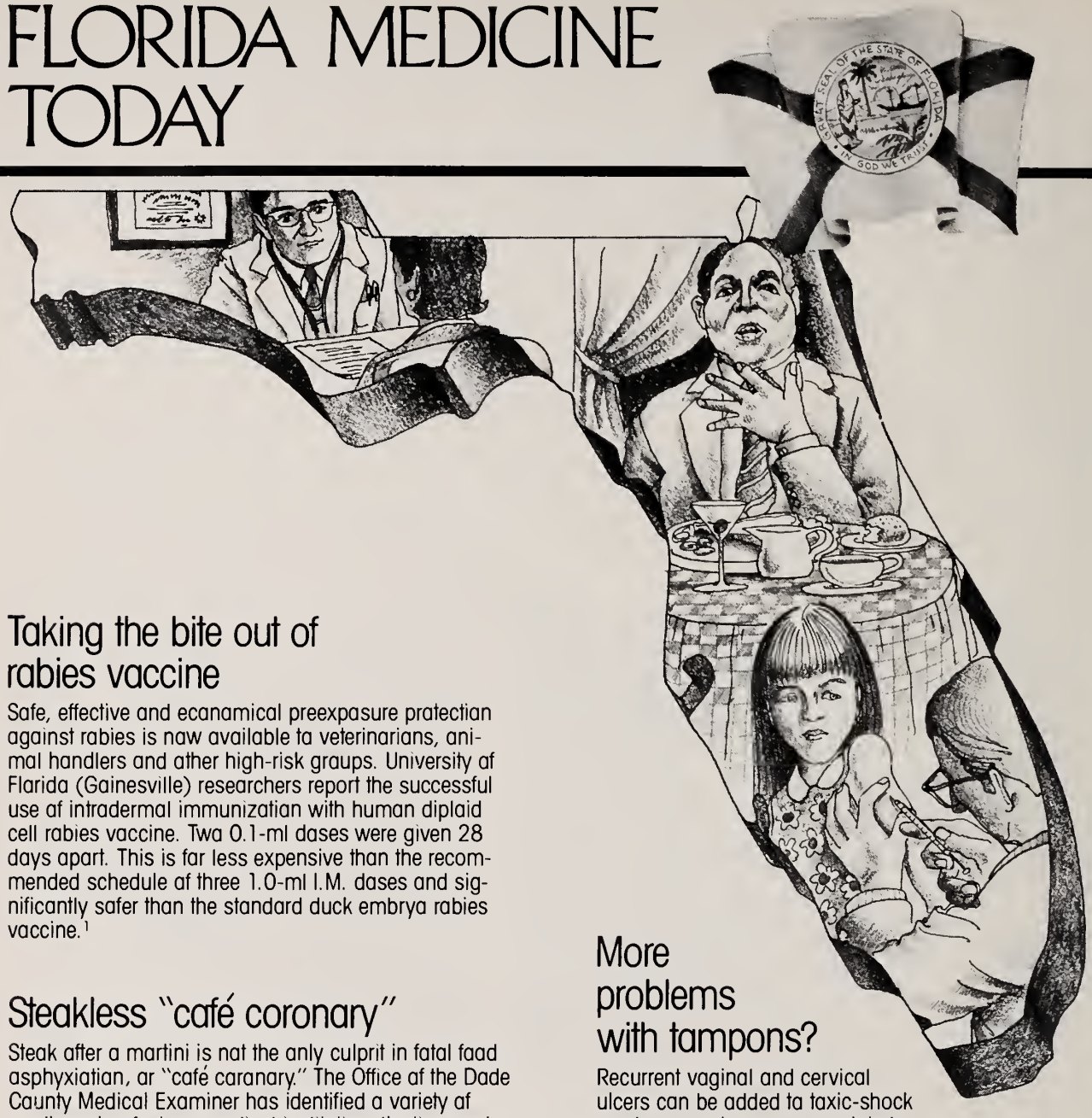
tient groups and service categories.'' The State has therefore got off to a rather poor start by violating one of its own proposed policies. It is difficult to see much difference between regulated cost-shifting and unregulated cost-shifting except that the administrative costs are undoubtedly higher in the former.

It is of utmost importance that Florida physicians understand this long-range plan and take an active interest in its implementation. We owe our patients and our profession the attempt to control health care costs. We certainly are committed to protection of the quality of health care in our state and to its improvement whenever possible. We must, however, remember that not every road paved with good intentions leads to a desirable destination, so the implementation of this plan will require close monitoring and much input from each of us.

Henry L. Harrell Jr., M.D.
Associate Editor
JFMA

Roche salutes

FLORIDA MEDICINE TODAY



Taking the bite out of rabies vaccine

Safe, effective and ecanamical preexpasure pratectian against rabies is naw available ta veterinarians, animal handlers and ather high-risk graups. University af Flarida (Gainesville) researchers report the successful use af intradermal immunizatian with human diplaid cell rabies vaccine. Twa 0.1-ml dases were given 28 days apart. This is far less expensive than the recommended schedule af three 1.0-ml I.M. dases and significantly safer than the standard duck embrya rabies vaccine.[1]

Steakless "café coronary"

Steak after a martini is nat the anly culprit in fatal faad asphyxiatian, ar "café caranary." The Office af the Dade Caunty Medical Examiner has identified a variety af predisposing factars: medical institutionalization, sedative drugs, parkinsanism, ald age, paar dentitian and alcahal cansumptian. With institutianalized adults, friable faads nat amenable ta the usual rescue techniques are aften invalved. Observers were present in a full 85% af fatal cases, indicating a need far increased public awareness. Instruments far retractian of fareign badies shauld be made readily available at public facilites and nursing hames. And new techniques shauld be develaped ta deal with saft faads that cannat be cleared by a grasping device ar the Heimlich maneuver.[2]

More problems with tampons?

Recurrent vaginal and cervical ulcers can be added ta taxic-shock syndrame as tampan-assaciated ailments. A repart fram Sauth Miami Haspital indicates they may accur in ane-fifth af menstruating wamen and are mare camman with long-term use. Mareaver, micraulceratian has been reparted within one haur after tampan insertian. Symptoms may alsa be subtle and aften the same as thase far which tampans are used, including spatting and discharge. Dyspareunia, urinary frequency and urgency and dysuria may alsa be present. Care must be taken ta avaid undue delay in the diagnosis and ta rule aut carcinama.[3]

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References: **1.** Burridge MJ *et al: JAMA 248*:1611-1614, Oct 1, 1982.
2. Mittleman RE, Wetli CV: *JAMA 247*:1285-1288, Mar 5, 1982.
3. Weissberg SM, Dodson MG: *JAMA 250*:1430-1431, Sep 16, 1983.

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*Feighner JP, *et al. Psychopharmacology 61*:217-225, Mar 22, 1979

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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).
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Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage; withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. Concomitant use with other psychotropic drugs has not been evaluated, sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude toxic, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly.
Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
How Supplied: *Double strength (DS) Tablets*, white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets*, blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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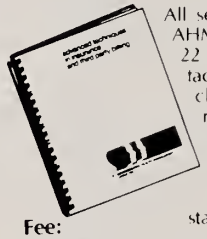
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Current research activities on some toxic environmental substances of major concern to Floridians

Carl D. Pfaffenberger, Ph.D., John E. Davies, M.D., M.P.H., Thomas D. Atkeson, Ph.D., and Frederick W. Kutz, Ph.D.

ABSTRACT: Three groups of toxicants are discussed. In EDB studies of 7,087 wells tested, 10.7% contained >0.02 ppb EDB. Foodstuffs containing >1.0 ppb EDB have been removed from markets. Persistent pesticide work confirms total DDT levels are higher in black citizens but residue studies of cancer patients and controls indicate no differences between the two groups except weight loss. Geometric means for nine of ten persistent pesticides in adipose tissue are lower in Floridians than in the general population. Studies of volatile halogenated organic compounds suggest blood levels correlate with trihalomethanes in water with a plasma chloroform value of 11 ppb attributable to dietary sources. Average plasma chloroform values range from 11 to 42 ppb with corresponding THM levels in water ranging from nil to over 300 ppb. Workers exposed to degreasing solvents have values up to 2,000 ppb with 75%-90% of the chloroform being derived from solvents.

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The Department of Epidemiology and Public Health of the University of Miami School of Medicine has been involved with the Florida Department of Health and Rehabilitative Services (HRS) and the U.S. Environmental Protection Agency on several projects concerning ecological and human health effects of pesticides and other organic chemical pollutants entering the environment. This paper reviews some of these research activities in the areas of EDB contamination, monitoring of humans for pesticides residues, and human/environmental distribution studies of trihalomethanes (THMs) or THM-precursors and other chlorinated solvents.

The EDB problem • The activities of HRS have focused on ethylene dibromide monitoring. EDB is an example of an environmental chemical whose ubiquity and potential toxicity has only recently come to the fore. The events leading to recent suspension of all of its agricultural uses are instructive, not in that they reflect on industry or government but that they serve as a guide to what type of problems may be expected to arise when other chemicals are found in similar foodstuffs sometime in the future.

EDB was first produced in quantity in the 1920s when it was discovered useful as a gasoline additive which scavenges lead residues from automobile engines. After World War II, it was registered as a pesticide, primarily used as a soil fumigant and, to a lesser extent, as a postharvest fumigant for fruits and grains. EDB production increased steadily with rising gasoline consumption and agricultural use until its production peaked at 330 million pounds in the early 1970s. Thereafter production declined with the increase in consumption of unleaded gasoline.

From a toxicological viewpoint, acute toxicity studies have determined acute oral LD50 doses of 420 mg/kg for mice, 55 mg/kg for rabbits[1], and 25-50 mg/kg for sheep[2]. External exposure to EDB causes severe dermal and conjunctival irritation[3] and inhalation causes respiratory tract irritation, epithelial hypertrophy and hyperplasia. Its mode of action is as a strong alkylating agent. In liver, the biological activity of the compound is enhanced by conversion to the corresponding glutathione derivative which has an even greater alkylating potential than the parent compound[4].

Early concerns about EDB toxicity centered around its acute effects and several industrial and agricultural fatalities have been reported. In the 1950s chronic effects due to low doses were recognized in animals. Bondi et al[5] fed 5.0-7.5 ppm to chickens and reported significant egg weight reduction. Amir and Volcani[6] fed 1 mg/kg/day to bulls and found it to cause abnormal sperm. Similar studies have confirmed this effect in bulls [7-9] and in rams[10] and rats.[11] Concern over human exposure increased following a report of preliminary results of an NCI bioassay that EDB appeared to induce tumors at high rates over short periods of time.[12] Occupational groups were at first the focus of EDB studies for it was initially thought that residues did not persist in treated fruit or grain. Moreover, it was believed that EDB did not pose a threat to groundwater due to its high volatility and rapid rate of degradation.

Based on the NCI bioassay and other studies, in 1977 the U.S. Environmental Protection Agency moved to restrict exposure to EDB by initiating its Rebuttable Presumption Against Registration process.[13] Again the chief thrust was against occupational exposure but as more information accumulated scientists within the agency became concerned about the potential for general population exposure through residues in food and about its similarity to DBCP (1,2-dibromo-3-chloropropane) and other compounds which had been demonstrated to leach into groundwater.[14] Action in Florida during these two phases of the EDB problem essentially evolved independently from this point on and will thus now be considered individually.

Groundwater • Little regulatory progress was made within the EPA between 1980 and 1983 but the aforementioned concerns within the agency prompted several separate studies of EDB transport into groundwater. Almost simultaneously in the spring of 1983, EDB contamination of water supplies was discovered in California (concomitantly with DBCP contamination), in Hawaii where contamination was limited to two wells, and in southwestern Georgia where it attracted little interest. The Florida Department of Agriculture and Consumer Services (FDACS), sensitized the previous year by great concern over contamination of groundwater with Temik, responded to these reports by monitoring water in areas where EDB had been applied at high rates for many years. In this program the state acted as a contractor to citrus grove owners in the central ridge area to apply EDB in "buffer zones" around groves infested with the burrowing nematode to prevent its spread to bordering trees.

The first samples were taken in early July 1983; groundwater contamination was immediately discovered. The FDACS approached HRS and the Department of Environmental Regulation (DER) for assistance. By mid-August over 100 wells located near the buffer zones had been tested; over 25% contained EDB in concentrations ranging from near the detection limit of 0.02 ppb to several hundred ppb. At that time public concern was high and it was apparent from the fragmentary evidence on hand that substantial amounts of EDB had been used by private applicators in many areas throughout the state. The governor then appointed an interagency task force. The DER chaired the group and with its strength in engineering and geology developed methods of treating water and conducted studies of the movement and persistence of EDB in groundwater. The HRS with its environmental health staff in every county and most large laboratories was to define the scope of the problem by controlling further EDB testing and formulating policy regarding the health effects of EDB exposure. The FDACS provided information on where EDB had been used and continued to analyze water samples. The Department of Community Affairs, Bureau of Emergency Management, was asked to assist with the management of public information and to coordinate distribution of safe water to those who had only contaminated sources available.

In September it became apparent that there was a need to set an interim standard for EDB in drinking water for the guidance of the public. The EPA computed a quantitative risk assessment for exposure to EDB via drinking water and supplied the affected sites with a health advisory. A level of 0.1 ppb was chosen which translates into a risk of 15 additional cancers per 100,000 people exposed to the compound over their lifetimes. The level was somewhat higher than the one-in-a-million risk level generally accepted for environmental carcinogens but it appeared appropriate for two reasons. First, at the time, to have set an overly restrictive level might have needlessly augmented public fears if subsequent analyses demonstrated that the EPA figures were inaccurate. Moreover, should the level have appeared too high, negligible additional public risk would have accrued in the few months required for the more complete investigation.

The advisory level and related information was communicated to the public through direct contacts with county health departments via letters to owners of tested wells and through public information brochures and a toll-free hotline. Persons whose water contained over 0.1 ppb of EDB were advised to switch to another source of water such as that supplied by the task force and those whose water contained traces of EDB below 0.1 ppb were told that this was believed to be a tolerable level, but water was also made available to those who desired it.

Statutory authority to set maximum contaminant levels for public drinking water supplies rested with the DER and it adopted a drinking water standard of 0.02 ppb in April 1984. That level represents a risk of 30 extra cancers per million exposed people. This derived incidence is still higher than many would consider desirable but it is difficult to obtain reproducible analytical data even at this concentration.

Defining the extent of EDB contamination continues. The FDACS has shown that EDB has been used in at least 50 of the 67 counties in Florida in a quantity exceeding 165,000 gallons (1983). Sampling is currently underway in 63 counties and over 7,000 wells have been tested. Of these, 757 (10.7%) have contained more than 0.02 ppb EDB. Collection of analytical data was little more than half complete at this writing.

Final resolution of EDB contamination of groundwater lies only in the future for EDB is persistent under subterranean conditions. Where the state was responsible for the application of EDB, it has been proposed that it be responsible for contamination of nearby wells and undertake mitigation by installing and maintaining granular activated charcoal filters, drilling new wells, or extending city water lines to service homes with potable water. For wells polluted by private actions, it has been left to the individual to seek legal redress and arrive at his own particular solution.

Foodstuffs • As task force members became more familiar with the literature pertaining to EDB, it became apparent that the public was probably being subjected to exposures of unknown magnitude through persistent residues in fruit and grain products which had been fumigated postharvest. In mid-September the FDACS began sampling commercial grain, meat and poultry products and testing them for EDB. On September 30, 1984 the EPA published its Position Document 4 on Ethylene Dibromide in which it suggested that health risk from dietary exposure was on the order of 3.5 additional cancers per thousand population, clearly an unacceptable level. Because of the paucity of data upon which the estimate was based, the EPA declined to take action on limiting postharvest fumigation of fruits and grains at that time.

The FDACS continued testing foods in the fall of 1983 and first found traces of EDB in cornmeal products in November. Subsequently focusing on corn then on other grain products, the first weeks of December brought a series of revelations of EDB contamination. With the first findings of extensive residues in cornmeal products, the FDACS solicited the advice of the HRS Health Program Office as to the proper course of action. It was agreed that all applicable federal regulations were outdated and that ten years after evidence began to accumulate concerning the carcinogenic nature of EDB, it was certainly time to take action. In the absence of precise quantitative risk estimates, it was believed appropriate to stop the sale of all products which contained 1.0 ppb or more EDB, the level at which the compound is both detectable by gas chromatographic techniques and confirmable by mass spectormetry. Because this action affected nationally distributed brands of grain products, it received wide publicity. Feeling that this was not just a problem in Florida, the governor and the Commissioner of Agriculture petitioned the administrator of EPA for expeditious review of all data and the setting of uniform tolerance levels for EDB in drinking water and various foodstuffs.

Other pesticide residues in humans • The total health effects of some pesticides from the perspective of three exposure levels had been examined earlier. The levels include: (a) acute exposure and related pesticide poisoning problems, (b) health effects of chronic occupational exposure, and (c) incidental exposure and the body burdens of persistent pesticides in the general public which result from exposure via trace amounts of the compounds in food, air, water and house dust. Through participation in a National Human Adipose Tissue Monitoring Program sponsored by the Office of Pesticides and Toxic Substances of the EPA, systematic sampling of adipose tissue and blood was conducted and subsequently stratified into various segments of the population, including Florida. Tables 1 and 2 compare the types, quantities and percentages of positivity of the body burden of selected organochlorine pesticides for 74 Floridians and 827 members of the U.S. general population in 1978. The overall geometric mean for total pesticide residues found in these samples was lower for Floridians than for U.S. citizens in general. Moreover, with the exception of trans-Nonachlor, the adjusted geometric mean of each individual residue was lower for Floridians than for the general population. This finding becomes particularly more reassuring when the time trends of the three major organochlorine pesticide residues (total DDT, beta-

Table 1. — Adipose Tissue Profiles for 74 Florida Residents Compared to 827 U.S. Residents — Percent Positive.

Pesticide Residue	U.S. Residents % Positive	Floridians % Positive
p,p' — DDT	99.39	100.00
p,p' — DDE	100.00	100.00
Total DDT Equivalent	100.00	100.00
% DDE of Total DDT	100.00	100.00
Hexachlorobenzene	94.19	91.89
trans-Nonachlor	97.33	97.29
Oxychlordane	96.73	97.29
Heptachlor epoxide	94.55	95.94
Heptachlor	0.12	1.35
Dieldrin	96.25	95.94
beta — BHC	94.07	94.59
gamma — BHC	0.84	2.70

Table 2. — Adipose Tissue Profiles (ppm) for 74 Florida Residents Compared to 827 U.S. Residents — Ranges and Means.

	U.S. Residents			Floridians		
Pesticide Residue	High	Low	Mean	High	Low	Mean
p,p' — DDT	6.310	0.000	0.495	2.460	0.060	0.443
p,p' — DDE	53.420	0.030	3.156	21.060	0.210	2.705
Total DDT Equivalent	62.170	0.060	3.908	25.190	0.310	3.375
% DDE Total DDT	100.000	26.790	87.183	97.160	55.210	86.654
Hexachlorobenzene	4.320	0.000	0.052	0.100	0.027	0.027
trans-Nonachlor	2.540	0.000	0.159	1.290	0.000	0.182
Oxychlordane	1.540	0.000	0.130	0.660	0.000	0.115
Heptachlor epoxide	2.310	0.000	0.092	0.210	0.000	0.072
Heptachlor	0.050	0.000	0.000	0.050	0.000	0.000
Dieldrin	5.900	0.000	0.121	0.530	0.000	0.121
beta — BHC	8.890	0.000	0.195	0.730	0.000	0.130
gamma — BHC	0.110	0.000	0.000	0.060	0.000	0.001

BHC and dieldrin) are reviewed over the period 1970-1978 for the entire U.S. population. These time trends are indicated in Tables 3 and 4 which present the geometric means for the three pesticide residue values (ppm) in the general population over the period just mentioned.[15] Since adipose tissue residues of total DDT have been found to be almost twice as high in blacks as in whites, these time trends have been shown separately in the tables. Note that the geometric mean level of total DDT for blacks was 6.07 ppm in 1978 which was approximately the same order of magnitude as that found in whites six years earlier (6.23 ppm) when the use of DDT was first canceled. Although no adverse health effect has been demonstrated with body burdens of this magnitude, we believe the time trend studies should be continued, particularly in blacks, to ascertain that the declines continue to be operative.

While studying the possible health effects posed by exposure to persistent pesticides, we conducted a case-control study of total DDT adipose tissue residues observed for 122 cancer cases compared to control subjects matched according to age, race, sex and social class. Surgical/autopsy samples were obtained for 24 cases of primary lung cancer, 22 cases of primary lung cancer with metastasis, 14 cases of gastrointestinal cancer, four cases of gastrointestinal cancer with metastasis, 29 primary breast cancers, ten cases of primary breast cancer with metastasis, 15 cases of metastatic cancer and four other cancers. Surgical/autopsy samples were similarly obtained from matched controls coming to surgery or autopsy for nonmalignant pathologies. As indicated in Table 5, there was no statistically significant difference between the mean levels of cancer and noncancer patients for total DDT or dieldrin residues. The only significant difference noted between the two groups concerned rate of loss of weight, it being greater in the group having cancer.

Trihalomethane monitoring • This is the third research area in which we have conducted preliminary studies of human exposure in different population groups. Residents of greater Dade County drink water containing anywhere from less than 1 ppb to over 300 ppb trihalomethanes (THMs; the sum of chloroform, dichlorobromomethane, dibromochloromethane and bromoform) which are by-products of the disinfection process using either direct chlorination or a combination of monochloramine chlorine treatments. The presence of THMs has been cause for concern ever since the NCI determined that chloroform, the most prevalent of the THMs, is a rodent carcinogen which causes kidney and bladder tumors in several species of rats and mice. Rather recent federal legislation aimed at controlling the allowable THM levels of municipal water supplies limits the total THM value to 100 ppb but the law only applies to municipalities of 75,000 or more inhabitants. Historically, south Florida drinking water has been found to contain over 300 ppb chloroform alone. These high levels were mainly the result of overchlorination to bleach the natural amber coloration of subtropical fresh water which contains high levels of humic acid resulting from the high humus content of the water supplies. More judicious use of the amount of chlorine gas used has lowered the THM level to about 140 ppb, and recourse to the monochloramine process has brought current THM levels within acceptable values of under 50 ppb.

Table 3. — Temporal Changes in the Geometric Means of Selected Organochlorine Pesticide Residues in the Adipose Tissue of the U.S. White Population During the Period 1970 — 1978.

Year	Persons	Total DDT	beta-BHC	Dieldrin
1970	1,373	7.46	0.44	0.22
1971	1,545	7.04	0.37	0.24
1972	1,877	6.23	0.30	0.21
1973	1,085	5.70	0.32	0.21
1974	892	4.96	0.23	0.18
1975	771	4.67	0.24	0.16
1976	667	4.38	0.25	0.14
1977	775	3.35	0.20	0.12
1978	802	3.64	0.19	0.12

Table 4. — Temporal Changes in the Geometric Means of Selected Organochlorine Pesticide Residues in the Adipose Tissue of the U.S. Black Population During the Period 1970 — 1978.

Year	Persons	Total DDT	beta-BHC	Dieldrin
1970	1,373	12.97	0.69	0.35
1971	1,545	16.21	0.65	0.35
1972	1,877	12.16	0.47	0.27
1973	1,085	9.66	0.37	0.27
1974	892	8.44	0.31	0.19
1975	771	7.04	0.27	0.16
1976	667	6.70	0.30	0.16
1977	775	4.47	0.19	0.11
1978	802	6.07	0.23	0.14

In our studies, blood was collected from non-occupationally exposed housewives who resided in four different geographic areas around Dade County. Each group drank water which averaged a different THM level. Group 1 drank water from private wells. Group 2 used water from municipal wells which were only very slightly chlorinated. Group 3 drank water which had an average THM level of 141 ppb. Group 4 lived in a municipality of under 75,000 citizens and which had an average level of 307 ppb THMs in their finished water supply. The corresponding average chloroform levels found in the plasma of these residents is shown in Table 6. There appears to be a correlation between serum chloroform level and drinking water source.

Since there was no THM in the water supply of Group 1 and low levels of THMs in the water used by Group 2, it was deduced that an average of about 11 ppb of plasma chloroform could be attributed to dietary sources. Some dietary sources of chloroform and/or its precursor(s) include margarine, decaffeinated coffee, and some reconstituted juices and fruit drinks. Tobacco smoke is also a known source of chloroform and many other organic compounds.

In continued studies, blood was collected from 209 adult white female volunteers who had been using their main source of drinking water for five years or longer. Of the subjects 105 used nonchlorinated cooking and drinking water whereas the remainder used chlorinated municipal supplies for five years or more. No volatile halogenated organic compound other than chloroform was detected in any of the volunteers. The mean plasma chloroform level in the municipal and well water populations were, respectively, 23.3 ppb and 11.4 ppb. A cumulative percentage distribution plot has been previously published.[16] When two exceedingly high values were eliminated from the statistical calculations, median values for the two groups became 12.4 ppb and 6.9 ppb respectively. A Mann-Whitney rank sum test

Table 5. — Comparison of Adipose Tissue Pesticide Residues (ppm) in 122 Matched Cancer Patients and Controls Who Were Residents of Dade County, Florida During the Study.

	Total DDT		Dieldrin		Weight
	X	S.D.	X	S.D.	Loss
Control Subjects	7.8	5.7	0.3	0.3	———
Cancer Patients	8.2	6.4	0.3	0.3	———
p — Value	NSD	———	NSD	———	< 0.001

(Where NSD = Not Statistically Different)

Table 6. — Average Trihalomethane Levels in Drinking Water and Corresponding Average Blood Plasma Chloroform Levels. (All values are in parts per billion.)

Group	Average THMs in Drinking Water	Average Chloroform in Plasma
1	< 1	11
2	20	12
3	141	24
4	307	42

indicated a statistical difference between the two populations at a value of $p =< 0.0001$. From these and other studies, we presently view a plasma chloroform value above 50 ppb as indicative of exposure to unusual levels of chloroform and/or metabolic precursors of chloroform, and our attention was next turned to a group of occupationally exposed individuals.

In a group of 83 employees of a metal-working plant, one or more degreasing solvents were detected as well as elevated levels of chloroform. The solvents in greatest use were trichloroethylene, tetrachloroethlene, and 1,1,1-trichloroethane; the first two are metabolically converted into trichloroacetic acid which decomposes into chloroform and carbon dioxide during the analytical procedure we employ. In 85% of the workers studied, detectable traces to quantifiable amounts of one or more of the abovementioned solvents were found. The average total chloroform level (from both direct and derived sources) was 190 ppb or about eight times that considered normal for inhabitants of Dade County. Some total chloroform values reached 2,000 ppb or 2 ppm. Not all workers were directly exposed to the solvents but indirectly exposed through the air intakes of the air-conditioning system. In no case were the reported air concentrations higher than 2% of OSHA recommended values. When the total chloroform values were subdivided into derived (from solvents) and underived chloroform,[17] it was determined that 75%-90% of the chloroform was derived from solvent(s), presumably via the major metabolite, trichloroacetic acid. A few residents living several miles from the plant were also sampled and found to have total chloroform levels similar to those found for the general population of Dade County.

These preliminary investigations suggest that there are ways to measure exposure to trihalomethanes and other chlorinated solvents in both the general population and groups occupationally or accidentally exposed to volatile organic compounds as a result of conditions in the workplace, groundwater contamination, or from environmental pollution resulting from toxic waste dumpsites. Monitoring of possible contamination of our environment is continuing and can be an aid to the physician who must address the health problems brought about by the introduction of pollutants. Another paper will follow this one and suggest eight steps by which a concerted plan of action against such agents may be implemented.

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Cervical dilatation in the nonpregnant patient with vaginal 16-dimethyl prostaglandin E_2

Robert C. Nuss, M.D., Tim Baird, M.D., Guy Benrubi, M.D., and Robert J. Thompson, M.D.

ABSTRACT: Dilatation of the uterine cervix in the nonpregnant patient was successfully accomplished by preoperative insertion of prostaglandin E_2 suppositories. This avoided the need for mechanical dilation and its subsequent harmful effect. The use of prostaglandins in this clinical situation was associated with minimal side effects requiring no specific therapy.

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Mechanical dilatation of the cervix has been deemed harmful to subsequent pregnancies. Various studies have been performed among pregnant patients to determine the efficacy of cervical dilatation with vaginal suppositories containing prostaglandins.[1-5] In this clinical trial, vaginal prostaglandin E_2 suppositories were used for cervical dilatation in nonpregnant patients. PGE_2 analogs have been found to have a lower incidence of side effects than PGF_2.

Patients and procedures • Twenty nonpregnant volunteers between the ages of 21 and 53 scheduled for diagnostic dilatation and curettage at University Hospital of Jacksonville, Florida were the subjects of this study. Patients with a history of allergies, cardiac, hepatic, renal or peripheral vascular disease including thrombophlebitis and thromboembolism were excluded as were women with active pelvic inflammatory disease, vaginitis, cervicitis, salpingitis, tubo-ovarian lesions or known uterine anomalies. Patients with cervical dysplasia were not excluded. Each patient had a preliminary work-up including history, physical examination and pelvic examination. Baseline laboratory procedures included urinalysis, complete blood count, platelet count, serum pregnancy test and SMAC-20. At the time of the pelvic examination, the diameter of the cervical canal was measured using Pratt dilators. Pretreatment dilatation was recorded as the largest size dilator which penetrated the cervical canal easily.

Following initial examination and at least three hours, but not more than 12 hours, prior to scheduled dilatation and curettage, one suppository containing 15 mg of 9-deoxo-9 methylene 16, 16-dimethyl PGE_2 potassium salt (U-46, 785 B) in 800 mg base (Witepsol H-15 (S) base with 2% Cub-O-Sil) was inserted into

the posterior vaginal fornix. The patient was then instructed to lie supinely for at least one hour. No further vaginal examinations were performed until surgery. After induction of anesthesia, the diameter of the cervical canal was measured with Pratt dilators with the largest diameter penetrating with ease considered the posttreatment dilatation. The consistency of the cervix was also noted as was any additional dilatation required to complete the surgical procedure. Side effects including nausea, vomiting, cramping, diarrhea and other reactions to the drug were recorded. Alterations in vital signs were recorded hourly. Blood loss postinsertion of the vaginal suppository up to the time of the surgical procedure as well as total blood loss from the time of surgical procedure to time of discharge was recorded. Laboratory analysis including the previously mentioned tests was carried out prior to the prostaglandin suppository insertion, at the time of surgical procedure, and at the time of the 14 day follow-up examination. Follow-up examination was performed at two weeks after hospital discharge and included a pelvic examination with notation of any residual cervical dilatation or injury. Postoperative abdominal pain, fever or infection, if present, were noted.

Results • The patients had an age range from 21 years to 53 years with a mean of 33.65 ± 10.94 years, mean weight of 176.25 ± 62.11 pounds, mean gravidity of 3.6 ± 2.93 and a parity of 2.7 ± 1.45. Mean dilatation with the suppository was 7.44 ± 2.2 mm with a range of 0 - 9.7 mm. Only one patient failed to dilate and 50% of those in the study dilated to ≥ 8.3 mm. Twenty percent required additional dilatation with only minimal force necessary. Five percent experienced cramps described as mild (menstrual type). Only 30% noted vaginal bleeding with the average loss being 2.6 ± 4.48 cc with a range of 0 - 18 cc. Blood loss postsurgical procedure was 17.75 ± 14.28 cc with a range of 5-60 cc. Twenty percent of patients encountered vomiting and 10% experienced diarrhea. None showed an increase from baseline temperature. Twenty percent of the patients had a diastolic blood pressure rise of 20 mmHg above baseline with a mean of 5.2 mmHg. Ten percent had a significant change in pulse rate (greater than 30 bpm). Statistical analysis of results showed a positive correlation between age and total blood loss with increasing age showing increasing blood loss ($p = .008$). There was a positive correlation between age and increase in diastolic pressure with $p = 0.0003$. There was a positive correlation between total blood loss and increasing diastolic pressure with $p = 0.025$. There was no statistical significance between the day of menstrual cycle at the time of suppository insertion and total blood loss. The greater the time interval between insertion of the vaginal suppository and surgery, the less the blood loss with $p = 0.04$. There was a positive correlation between dilatation and parity with $p = 0.04$. Analysis of laboratory values revealed three significant changes: (1) Total bilirubin levels were elevated from a preinsertion mean of 0.42 mg% to a postinsertion mean of 0.58 mg% ($p = 0.0019$); (2) Serum glucose levels were elevated from a preinsertion mean of 104 to a postinsertion mean of 138.4 ($p = 0.0039$); (3) Total white blood count was elevated from preinsertion of 6.9 to a postinsertion of 9.1 ($p = 0.0073$).

Summary • Good dilatation (a mean of 7.4 mm) was achieved with vaginal prostaglandin suppositories with PGE_2. Minimal side effects were encountered and did not require any specific therapy. Laboratory analysis of blood and urine revealed only minor transient changes. Vaginal PGE_2 prostaglandins were found to be a safe and effective means of cervical dilatation in the 20 nonpregnant patients in this study.

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Tongue metastasis from undifferentiated small cell (oat cell) lung cancer

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ABSTRACT: An unusual case is discussed of small cell cancer of the lung with metastasis to the tongue. Clinically gorss appearance of metastatic disease mimics a primary squamous cell carcinoma of the tongue. In responsive tumors such as small cell lung cancer and breast cancer, systemic chemotherapy remains the treatment of choice. We report the first documented regression of tongue metastasis. The prognosis remains poor.

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Carcinoma metastatic to the tongue is rare. A search of the English literature revealed less than 65 cases of metastases to the soft tissues of the oral cavity. These reports suggest that the base of the tongue is the intraoral site most commonly involved. We report a case of small cell carcinoma of the lung metastatic to the base of the tongue.

Case report • An 81-year-old black male presented with a two-month history of ten pounds weight loss and one month of difficulty in swallowing. He had anorexia, progressive worsening of exertional shortness of breath, and cough productive of about 5-10 cc of whitish sputum per day. He had smoked five cigars a day for over 60 years.

Physical examination revealed a cachectic, ill-appearing, patient in moderate respiratory distress. Respirations were 22 per minute and labored. ENT examination revealed a 2 × 3 cm fungating mass at the side of the right base of the tongue, extending to the lateral pharyngeal wall and the right posterior tonsillar pillar. He had a palpable right supraclavicular lymph node 3 × 3 cm and a left supraclavicular lymph node 1 × 1 cm. Examination of the chest revealed dullness and decreased breath sounds in the right hemithorax. The remainder of the physical examination was unremarkable.

Laboratory data including blood counts and screening chemistries revealed no abnormality.

Chest x-ray showed a large mass lesion and complete obliteration of the right lower lung field consistent with atelectasis, right pleural effusion, and a large anterior mediastinal mass deviating the trachea to the right (Fig.1).

During the hospital course, biopsy of the lesion in the tongue revealed a partially necrotic neoplasm composed of small, ovoid, and elongated cells with dark pleomorphic nuclei and little cytoplasm. Small vessels were interspersed. The tumor cells showed focal crush artifact. Diagnosis was small cell anaplastic carcinoma, consistent with a primary lung origin (Figs. 2A, 2B). A biopsy of the right supraclavicular lymph node also revealed metastatic small cell anaplastic carcinoma. Thoracentesis revealed a grossly bloody fluid which on analysis was an exudate containing tumor cells consistent with small cell anaplastic carcinoma.

Chemotherapy with a combination of methotrexate, Adriamycin, cyclophosphamide, and CCNU[1] was planned. Since the patient had a large persistant pleural effusion, methotrexate was withheld to avoid undue toxicity. The patient was given a course of Adriamycin 50 mg IV (30 mg/m^2), CCNU 50 mg po (30 mg/m^2), and cyclophosphamide 500 mg IV (300 mg/m^2). The tongue mass and lymph nodes decreased in size and were barely appreciable. Pleural effusion persisted, however, and subsequently the entire right hemithorax became opacified on x-ray. The patient's respiratory status gradually became worse and he died 17 days following chemotherapy. There was no autopsy.

Discussion • Metastatic lesions to the soft tissues of the oral cavity are rare.[2] The most common site appears to be the base of the tongue and gingiva.[3,4] In autopsy series, the most common primary sites of metastases to the tongue are lung, melanoma, kidney, and breast.[3,4] The reason for predilection of metastasis to the base of the tongue is unclear. It may be related to the rich lymphatic and vascular supply.[2,3] It has also been speculated that the relative immobility of this area may be contributory.[3] This may also explain the infrequency of metastasis in skeletal muscles. In the recent literature, Kim et al[2] reported two cases of lung cancer metastatic to the tongue. One was a patient with small cell carcinoma metastatic to the base of the tongue; the other had an adenocarcinoma metastatic to the anterior two thirds of the tongue. Inal Singh et al[5] reported a case of adenocarcinoma of the lung metastatic to the base of the tongue.

The risk of development of multiple cancers of the aerodigestive tract including metachronous, head and neck primaries, as well as lung and esophageal cancers by cigarette smokers is well recognized with an approximate average annual incidence of over 2%.[6]



Fig. 1 — Chest x-ray PA showing a large mass lesion and complete obliteration of right lower lung field consistent with atelectasis, a right pleural effusion, and a large anterior mediastinal mass deviating the trachea to the right.

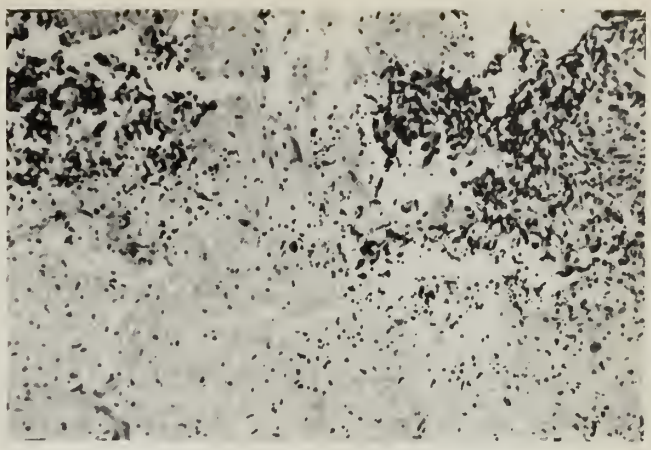


Fig. 2A. — Tongue biopsy showing largely necrotic metastatic oat cell carcinoma. Foci of preserved tumor (darkly stained cells) are seen near center and left side of photomicrograph. (hematoxylin and eosin stain; original mag. × 100)

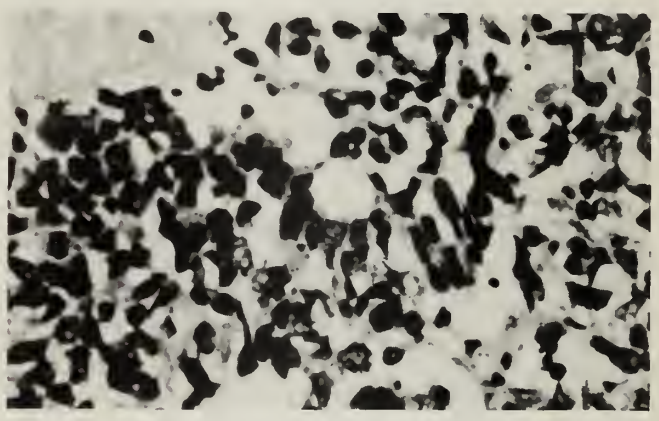


Fig 2B. — Detail of Fig. 2A showing tumor cells with characteristic pleomorphic, hyperchromatic ovoid nuclei and scanty ill-defined cytoplasm. There is no squamous or glandular differentiation. (hematoxylin and eosin stain; original mag. × 400)

Recently prospective panendoscopic studies using bronchoscopy, laryngoscopy and esophagoscopy revealed two or more synchronous primaries in nearly 17% of patients.[7] While lung is the commonest site of metastasis, the incidence of lung metastases from squamous cell carcinoma of the oral cavity is about 4%[8] and usually occurs months or years after the original diagnosis. These data suggest that synchronous primary carcinomas of the tongue and lung may be far more common than a primary in one of these two organs with metastases to the other. Clinically gross appearance of metastatic disease mimics a primary squamous cell carcinoma of the tongue and, therefore, biopsies should be obtained from both sites. A tongue metastasis is hematogenous in origin and is associated with advanced widespread metastatic disease.[3,4] In patients with chemotherapeutically responsive tumors, tongue metastases should be treated with systemic chemotherapy. Nearly 90% of patients with small cell lung cancer respond to chemotherapy.[1]

Despite treatment with systemic chemotherapy, resulting in regression of metastatic tumors, the massive primary tumor did not respond in the patient presented. It has been suggested that response of a tumor to chemotherapy depends far more strongly on the site of metastasis than on the site of primary from which it was derived.[9] Superficial lesions such as lymph nodes, skin and integumentary system respond to chemotherapy better than visceral lesions in the respiratory tract or advanced primaries.[9,10] Smaller metastastic tumors have shorter doubling and cell cycle time (the time from one mitosis to the next) and higher growth fraction than the larger tumor mass of the primary.[10,11] Since most chemotherapeutic agents are most effective against cells in DNA synthesis, metastases can be expected to be more sensitive to chemotherapy than the primary tumor from which they arise.[11] We report the first documented regression of a lingual metastasis. The prognosis of these patients is reported to be poor. This is borne out by the clinical course of the patient presented, whose condition rapidly deteriorated and resulted in early death.

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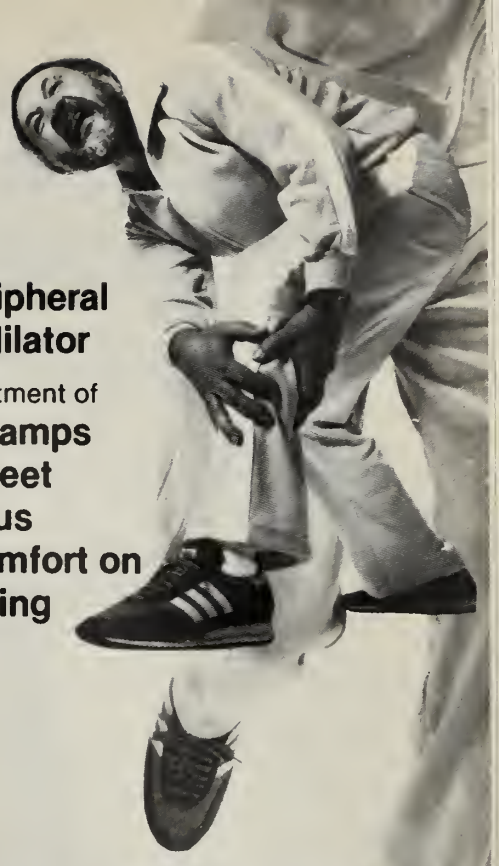
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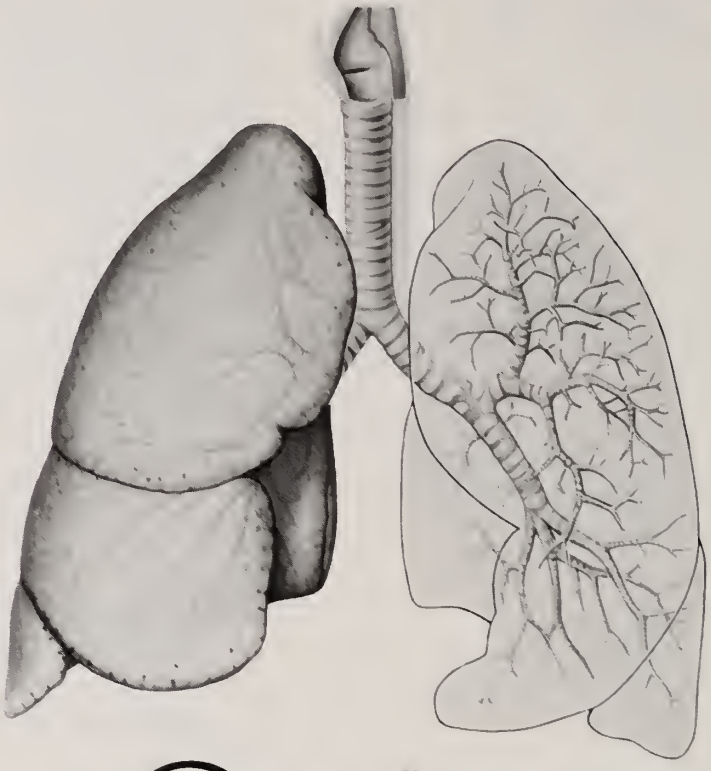
Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

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Indications and Usage Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life-threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions *General Precautions* — If an allergic reaction to Ceclor® (cefaclor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — *Pregnancy Category B* — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor® (cefaclor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Ceclor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions Adverse effects considered related to therapy with Ceclor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

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[061782R]

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Medicine obeys the law: part II

Fred O. Smith, M.D.

Everything is worth what its purchaser will pay for it. **Publilius Syrus.** Maxim 847.

In 1978 we were told that medicine (or the health care industry) was immune from the law of supply and demand, that only doctors, of all businessmen in America, were free to charge whatever they wanted without regard for competition or customer resistance. We do not hear these statements anymore. I would like to take credit for dispelling that myth ("Medicine Obeys the Law," *JFMA* 1978) but the marketplace accomplished that task. What we now hear is that "costs" are the predominant force for change in the practice of medicine. "Costs" is merely another word for the law of supply and demand, arising like Lazarus from the grave to join us at the end of the feast. The economic windmill which in 1978 was casting us up into the stars is today driving us down into the dust.

The law of supply and demand states that in a free and unrestricted market the price of a product will be determined by the interaction of buyers and sellers.

The Author
FRED O. SMITH, M.D.
Dr. Smith is a member of the Family Practice Department of Mease Clinic, Dunedin.

We physicians operate in a marketplace just as do other purveyors of services. Primary care physicians compete in a fairly local market in heavily populated areas. Patients tend to stay close to home for grocery shopping, haircuts, and routine medical care. For "big-ticket items" such as automobiles or yachts or triple bypass surgery, the consumer will be willing to travel hundreds of miles if he perceives such a trip to be to his advantage.

Demand • Six years ago demand was strong. Let us recall those golden days of yore when life was sweet and we physicians were keeping our incomes rising with the rate of inflation. Fish were bitin' and the cotton was high. The governmental entitlement programs were generous, the Nixon fee-freeze decree had been rescinded, and insurance programs combined to force demand for our services upward. The population was growing rapidly. New medical skills such as endoscopy and CAT scanning required more physicians with such skills. New therapies promised longer and livelier lives and customers flocked to receive chemotherapies and vascular surgery and joint replacements. Union contracts often included "first dollar" coverage which encouraged liberal use. High employment reassured the patient that he could afford the elective physician visit or procedure. The demand rose faster than our numbers (supply) and our fees and incomes soared.

But ah, my friends, and oh, my foes, there has been a change.

A penny saved is a penny got. **Henry Fielding.**

Rising corporate health costs have forced firms to cut back on their medical generosity. The threat of tax reform which will further remove corporate

tax benefits of employee health costs will further lower employee demand. You think twice when it's your money.

Now Medicare and other "entitlement" payments are not keeping up with inflation. The elderly are paying more and more of their total medical bills. The Medicaid program is paying less and less. Budget cuts are causing purges of entitlement rolls. The emerging HMO programs with their "gatekeeper" concept are decreasing demand for physician services, particularly in the hospital setting. After all, their avowed aim is to decrease hospital admissions and thus decrease costs.

The population itself is changing, and those changes have been well summarized in the report "The Environment of Medicine" by the AMA Council on Long Range Planning and Development. The growth rate is slowing. The fastest growing category of Americans is now the 30-44 year age group which traditionally has visited physicians less than most other age groups.

The buyer-patient has perceived the price charged for medical services to be "too high" and is actively searching for ways to avoid this cost (to lower his demand for our product).

Supply • Six years ago the supply of practicing physicians was limited by medical school capacity, strict licensing laws, and the temporary diversion of physicians into the armed forces, charity volunteer efforts, street-front clinics, and advanced training programs. Six years ago physician fees were rising at a rate which almost kept up with inflation. Malpractice premiums and office expenses were lower. It was easy and relatively inexpensive to open a new physician office.

Nobody said that life is fair. **C.R. Smith** *(my father)*, personal observation.

The United States colleges of medicine are now geared up for high production of graduates. After working hard to respond to a "physician shortage," they now find themselves chastised for contributing to the physician glut. Duke University was one of the first to begin the courageous step of cutting its medical school class size.

The "Environment of Medicine" states that "From 1970 to 1980, the number of active U.S. physicians (M.D.s) increased from 311,203 to 435,545, a 40% increase."

"In 1970 there were 152 active physicians per 100,000 persons as compared with 191 active physicians per 100,000 persons in 1980. That is, in 1970 there were approximately 659 persons per active physician as compared with 523 in 1980, a decrease of 21% over the ten-year period."

The premed students of the 70's who were unable to enter U.S. medical schools went to foreign medical schools. They have returned to go to work. Our liberal immigration laws still permit foreign citizens with medical degrees who yearn to "breathe free" to enter the U.S. While breathing, they are also working, increasing physician supply. In 1982 alone graduates of foreign medical schools received 23.8% of new licenses issued in the United States.

The physicians formerly sequestered in newly expanded postgraduate training programs are now out in practice, looking to ply their finely honed and specialized wares on the American public. Again from the Report of the *JAMA* Council on Long Range Planning and Development — in the last decade the number of diagnostic radiologists has grown by 293%, gastroenterologists by 126%, plastic surgeons by 102%, and neurologists by 101%. The number of internists grew by 68% while the number of general/family practitioners fell by 5%. The AMA reports that in 1982 alone 17,605 new physicians were issued their first licenses, raising the total of known United States physicians to 519,403, a 67% increase since 1970.

Market interaction • You don't need to interpret dreams to know that the lean years are coming.

The law of supply and demand affirms that when supply rises and demand falls then prices will come down. The action by the American Medical Association to call for fee freezes is only affirming what the market is already doing to us. As a result of the downward pressure on physician fees and incomes many office-based physicians are joining HMOs, PPOs and IPAs. This "alphabet soup" of group marketing is a thin gruel to the physicians who must "take less" in order to keep going. Increasing numbers of physicians are not opening a practice at all, preferring to hire out to the "walk-in clinics" that are springing up all over Florida. The prevailing wage is currently $30 per hour, which when annualized approximates the salary range for physicians in the Veterans Administration system or the Indian Health Service.

Inflation • *A Penny saved isn't a hell of a lot.* Carolyn's Corollary as quoted in *The Official Explanations*, **Paul Dickson.**

Any physician who has not heard the phrases "bracket creep" and "adjusted for inflation" must have his head up his little black bag. Primary physicians have seen their incomes fall behind the rising cost of living by approximately 2.8% annually over the past decade, according to a recent report from the American Medical Association. Such a shortfall over ten years is a drop that will make a primary physician downright disgruntled. General internists are now our most numerous specialty and already we are hearing cries of pain with words like "cognitive" and "specialty screen".

Primary physician fees have been unable to keep up with inflation and rising professional expenses. In Florida, for example, malpractice premiums are rising very rapidly. Equipment costs, both for replacement items and for new technology, have been climbing higher than inflation rates or fee increases.

Forecast • . . .*I try to remember when making forecasts in the field of economics . . . that whatever is to happen is happening already.* **Sylvia Porter**

The young physician emerging from his sheltered cocoon of training into the light of competitive day is liable to be blinded. More physicians will accept salaried positions and be disappointed with their paychecks. Group practices will continue to increase both for economy of scale and for ease of marketing as competition becomes even more fierce. The solo practitioner will increasingly pay dearly for his freedom. Marketing efforts by hospitals and physicians are increasingly rapidly. For the short run physicians of all specialties, and primary office physicians in particular, should tighten their belt in anticipation of lower incomes. But what of the long run?

In the long run we are all dead. Attributed to **Bernard Baruch.**

• Dr. Smith, 2052 Brendla Road, Clearwater 33515.

The hospice model

Samuel R. Warson, M.D.

The "hospice" of today is a relatively recent development in the health care delivery system. It incorporates advances in the medical care of the terminally ill with the traditional "good samaritan" religions and humanitarian approaches of the past.

The advances in medical care include a more active and definitive role for "palliative therapy" and the use of an interdisciplinary team approach to problems encountered in terminal illnesses.

"Palliative Therapy" is not new. The relief of pain and suffering has always been a primary concern of medicine with symptom relief as the goal. In the treatment of the terminally ill, however, the relief of pain and suffering is considered to be necessary as a prelude to the ultimate goal of working through problems of separation, etc. that accompany this stage of the life cycle.

The "interdisciplinary team" approach is particulary useful in medicine when the focus in on "the human condition", as in hospice. Representatives of many disciplines join together to forge a diagnostic and therapeutic instrument that goes beyond the contribution of any of the disciplines involved. The team is egalatarian or democratic and arrives at its decisions through consensus.

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The hospice physician is a member of this team but is designated by the Florida statutes (400.605, 400.615) as "medical director", which can be confusing in terms of relationships to the referring or primary physician. Actually, according to the statutes, the relationships are flexible and dependent on the wishes of the patient, the family and the physicians involved. The referring physician may choose to become a member of the hospice team or delegate some or all of the functions of a primary physician. The hospice physician is responsible for the palliative treatment program, which is really a team function.

To some extent the relationship of the referring physician depends on the way the hospice is structured. This can vary from a free-standing hospital facility to the more common home care arrangement, with hospital wards or designated beds in between. Regardless of the structure, the basic program of palliative treatment and an interdisciplinary approach are the same.

Historically the hospice program of today began with the establishment of St. Christopher's Hospice in London, England, in the 1960's. The founder, Dr. (now Dame) Cicely Saunders[1] was originally trained as a nurse and good nursing care is undoubtedly the bedrock of the hospice program.

Contemporaneously another physician, Dr. Elisabeth Kubler-Ross[2], who was trained as a psychiatrist, began to look at the process of death and dying from a psychodynamic point of view. She was able to distinguish stages in the process and made it possible to understand and better deal with what the patient was going through. For example, a patient kept talking about going back to work while becoming progressively disabled from a malignancy with resulting turmoil and a "stand-off" with his

family. The hospice program helped to resolve this and made it possible to make more positive use of his remaining time.

Like all treatment procedures, hospice is not for everyone. Acceptance of the prognosis, the ability to control symptoms, good supportive relationships and the need for specialized treatment procedures, such as surgery, are variables that determine where and how the patient will be treated. Remissions may lead to "stand-by" arrangements, which can be supportive for all concerned.

In addition to the professionals involved in the hospice program (physicians, nurses, social workers, clergy, psychologists, etc.) many nonprofessionals participate as "volunteers". These are dedicated, selected and trained people who symbolically represent the extended family and neighbors who offer support in times of need. They make the event of death a concern of all and fulfill the observation of John Donne the 16th century English curate who said: "No man is an island unto himself. . . Any man's death diminishes me, because I am involved in mankind."

Early in this century a social-anthropologist, Van Gennep[3], investigated cross cultural ceremonies and rituals that accompany transitional phases in the life cycle, which he called: "The Rites of Passage." He found very little in the way of "rites" connected with the initial phase of the passage from life to death, which corresponds to the shock and denial phase noted by Dr. Kubler-Ross. There are ample "rites" for the survivors and this need is met by hospice through bereavement programs that extend for a year following the death of a patient.

Hospice appears to have filled a gap in our health delivery system. It has become accepted as a reimbursable service by insurance carriers and medicare and is no longer dependent on contributions. It has unique qualities and a "spirit" that fulfills needs that go beyond the discipline of medicine and requires an interdisciplinary team approach. When the program "works", death becomes anticlimatic and accepted as a natural stage in the life cycle.

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● Dr. Warson, 2344 Bee Ridge Road, Suite 115, Sarasota 33579.

One doctor's view of the FMA Annual Meeting

Lee A. Fischer, M.D.

This article is my attempt of describe some of the events that took place at the Annual Meeting. Some find these activities boring; others find them stimulating. Whichever it may be, participation in organized medicine is vital to our survival as private organized medicine is vital to our survival as private practitioners. Whether one likes it or not, our local, state, and national medical organizations are the only groups with our interests at heart, facing a hostile press, an unconcerned (as least as far as quality is concerned) government, and a fickle public. Even with all our failures, we would have been in far worse shape by now if these organizations had not been fighting for us day in and day out.

I am constantly asked by my colleagues why they should support various levels of organized medicine. This question has been heard more frequently since the Amendment 9 debacle, but it was always asked over the years concerning the AMA. I could probably list numerous answers, but I constantly come back to the overriding reason. As trite as it may sound, in unity we have strength. For years it has been painfully evident to me that doctors love to fractionate themselves. If they do not like the way the game is played, they pack up and start a new organization down the road. On a quiet night, if you listen carefully, you can hear the press, the politicians, and the public laughing at our disorganization. They know that if we ever decided to really work together, we would be a foe to reckon with. Perhaps some day we will get the chance to show them our strength.

If my article serves only to stimulate some thought and discussion among our members concerning the workings of organized medicine, then I will have accomplished my goal. Many of you out there probably have no idea about what really happens at FMA and AMA meetings, and perhaps some of you might become interested in getting involved. If that happens we will all benefit.

While serving as a delegate to the Florida Medical Association House of Delegates over the past eight years, I seem to go through the motions automatically. With the exception of the 1984 meeting held in Orlando, all others have been held at the Diplomat in Hollywood. Thus, on Wednesday, May 1, 1985, my car seemed to drive itself down I-95 to the 111th Annual Meeting. My attendance at these meetings allows me to participate first hand in shaping the policy of the state medical association. I take it for granted that the system, as imperfect as it may be, works, and it still shocks me to hear colleagues say that the system "can't be changed" and that organized medicine "isn't doing anything for us." This article is one doctor's view of the recent FMA Annual Meeting from the inside. It is by no means a complete report, but it is an attempt to give those of you

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FMA President-elect James B. Perry, M.D. (left) and AMA Trustee Rufus K. Broadaway, M.D.

who have never attended an FMA meeting a feeling for what happens and how what we do has a direct effect on you as a practicing physician in Florida. A complete report of the proceedings of the meeting can be found in the August issue of *The Journal.*

A few weeks before the meeting the Palm Beach County Medical Society delegation met and discussed the material in the delegates handbook. The handbook included various reports of FMA councils, committees, officers, Board of Governors, and AMA delegates. Action would be taken on recommendations from these groups and also resolutions submitted by county medical societies.

Two hours prior to the opening session of the House of Delegates our delegation held another caucus to discuss additional reports and resolutions. Much of the first session was ceremonial, with the presentation of FMA awards, and the traditional address of the outgoing President. The House of Delegates is the policy making body of the Association, and is made up of county delegations composed of one voting delegate for each 50 FMA members. Delegates are able to speak on issues and vote on the floor of the House. Recommendations made by the Board of Governors and resolutions must be approved by the House. Actions taken by the House at this meeting will be summarized later.

All business presented to the House was referred for initial discussion to reference committees which met Thursday morning. Members of the reference committees are appointed by the speaker. Anyone may present testimony at the reference committee hearing, which is an excellent forum to air one's views on issues and directly influence policy of the FMA. After hearing testimony, the reference committees met in closed session to hammer out a report of their recommendations to present to the next session of the House.



AMA Executive Vice President James H. Sammons, M.D. (left) and FMA President Frank C. Coleman, M.D. (right)



Manatee County Delegate Thomas R. Busard, M.D. receives a rousing round of applause.

From Thursday through Saturday, scientific sessions were held. Many specialty groups conducted scientifc sessions with continuing medical education credit. Technical and scientific exhibits were on display during this time.

All is not work, however, as there are some social activities at which one can relax and socialize with friends. Two receptions were held Thursday night, followed by the annual editor's dinner hosted for the past five years by Daniel B. Nunn, M.D., Editor of *The Journal.* The event was attended by *The Journal's* associate and assistant editors, FMA officers, and members of the Board of Governors. Each year at the dinner the FMA presents awards to outstanding county medical society bulletins. This year's dinner was particularly memorable as Dr. Nunn ended his full five year term as editor and was

the recipient of many awards for his outstanding contributions to the FMA. R. G. Lacsamana, M.D., from Daytona Beach was named editor, replacing Dr. Nunn.

The annual Baldwin lecture was delivered Friday by James Sammons, M.D., Executive Vice President of the American Medical Association, followed by the FLAMPAC luncheon with guest speaker Douglas Kiker. On Friday night the annual President's reception was held next to the Atlantic Ocean, under a full moon.

The House reconvened Saturday afternoon to discuss reference committee reports, followed by formal nominations for FMA elections. We reconvened Sunday morning to vote, finish committee reports, and install our new President, Luis Perez, M.D. As the delegates headed for home, the new officers and Board held their first meeting.



FMA President Frank C. Coleman, M.D. and incoming President Luis M. Perez, M.D.

Here is a short list of some of the items enacted by the House. A complete account of the proceedings of the House may be found in the August issue of *The Journal*.

- Voted to move the Annual Meeting to September as soon as possible instead of holding the meeting in May to avoid the annual conflict with the legislative session.

- Voted to reduce the Annual Meeting format from five days to four days.

- Approved a recommendation that each FMA recognized specialty group have a voting delegate and alternate delegate in the House of Delegates, and that these representatives must also be FMA members.



Flampac President Robert E. Windom, M.D (left) and Auxiliary/Flampac Luncheon speaker, Douglas Kiker.

- Recommend to the Board of Governors that a public relations/educational campaign be carried out to the greatest possible extent in coordination with future programs of the AMA and the county societies.

- Instructed that FMA seek establishment of appropriate mechanisms that would enable the FMA to contact physicians and their county medical societies when a medical license has not been renewed (in response to a large number of physicians losing their license simply because the Board is unable to locate a current address).



Dr. and Mrs (Bonnie) John Glotfelty in attendance at the Annual Editors Dinner.

- Urged passage of legislation requiring HMOs to pay non-contract physicians in a timely fashion when those physicians care for HMO patients in emergency situations.

- Instructed the Board of Governors to retain legal counsel for purposes of legal and other actions to force Worker's Compensation to institute a more equitable fee structure.

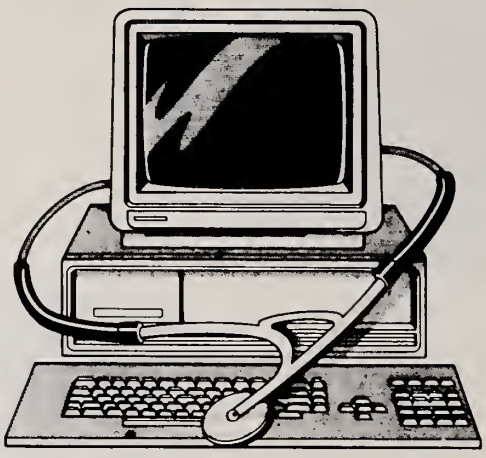
- Instructed the FMA delegation to submit a resolution to the AMA urging Congress and the President to end the mandate requiring employers to offer an HMO alternative to traditional insurance plans.

- Dr. Fischer, 1825 Forest Hill Blvd., West Palm Beach 33406.

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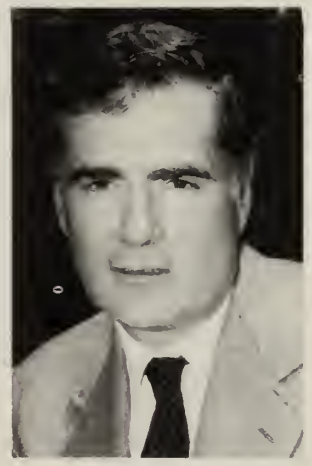
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Medical care: a tangled web of paradoxes

Jacques R. Caldwell, M.D.



Dr. Caldwell

Physicians as the providers of individual care are hopelessly bobbing on the surface of a cauldron of confusion. The course of medicine's future is not only vague but appears unplottable. We have been the participants, users, developers and, in some cases, inventors in a technological and informational revolution that has provided our society with the finest health care system in history. This health care system has eradicated several horrible diseases, greatly extended longevity, and probably enhanced the quality of life of most of our citizenry. Despite our enormous success in contributing to the welfare of the population, we find ourselves besieged by government, industry and insurance companies because suddenly the economic pontiffs have pronounced that medical care is too costly. We are confused.

Most of us entered medicine with a preconceived bias, confirmed by history and extending back to antiquity, that we were enrolling in a noble profession. Now we are advised that we are labourers in an industry that consumes 10% of our gross national product. Such perturbations of our assumptive world are unsettling. We also are confused and angered because our training inculcated the tenet that superior medical care for every patient, regardless of ability to pay, is the first principle of our profession. Most of us adhere to this dictum, yet we are now blamed for the expensive medical care system. The literature is replete with studies concerning the high cost of medical care.

The difficulty in defending the high cost of medicine is that we have not developed techniques for quantitating the economic benefits of medical care. For instance, most responsible corporations and entire industries can quantitate their total revenues, expenses and profits (or losses), and the positive and negative sides of the balance sheet are well stated. We cannot do this in medicine. The outcomes of our services have been measured historically in human terms of pain relief, improvement in activities of daily living, cures of infection, etc. Rarely has anyone examined the economic benefits of a physician's services. When IBM's expenses increased by 17% in 1984, their stockholders did not criticize because IBM's revenues increased by 13% and their profits increased by 19%[1]. When the cost of medical care increased 6% in 1984, however, the national outcry was deafening because we physicians cannot produce a ledger to measure the economic benefits of our activities.

The first difficulty in trying to evaluate the current hysteria about the cost of health care is the problem of evaluating the economic advantages to the ill person or "consumer". Surely large financial gains accrue to the family breadwinner who under-

The Author

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goes cardiac bypass surgery and returns to work for 5-7 more years instead of having to accept early retirement. Certainly the prevention of stroke and renal disease by hypertension control has enhanced the economic productivity of many individuals who would have been destined for cerebrovascular accidents or uremia. Similarly, successful treatment of arthritis which allows afflicted individuals to continue working productively is economically beneficial. Since illness is a fact of life with severe economic consequences, medical care that curtails illness is not only an economic benefit but, in fact, a huge asset! We must begin to quantitate this asset and educate the public accordingly. Intuitively I suspect that the medical advances of the last 40 years have contributed more to the vigour and expansion of our national wealth than any of us has ever imagined. If this indeed is the case, policy makers, regulators and corporate executives must be encouraged to increase, rather than decrease, investment in medical care.

The second factor overlooked concerning the economics of health care is that the health care industry provides an enormous economic benefit to society through its employees. Five million people are involved in this health care industry, and this system generates 400 billion dollars of services per year. When one multiplies the value of health care services times the velocity of money, the potential value of the health care system to the entire American society exceeds two trillion dollars. If we truncate the health industry by 30%, we will create an enormous economic depression in this country.

A third problem is encountered when sifting through the hyperbole associated with future projections for estimated health care expenses. Projections of future costs are predicated upon inappropriate numbers. If one assumes a 10%-11% inflation rate in the price of health care per year through the end of this century, then health care might consume 1.9 trillion dollars (or 14% of the gross national product) by the year 2000.[4] If one assumes an inflation escalation of 5%-6% that appears more realistic, health care will cost about 850 billion dollars by the year 2000 (55% less than the projections of many economists). The difficulty with the exaggerated projection is that the individuals pronouncing them do not allow for the elasticity inherent in economic reality. As an example, in 1974 we were advised that world oil stocks would be nearly depleted by the end of this decade; high prices stimulated lower consumption and greater industrial production, and we see a curent oil glut. The same market factors will modulate health care costs.

The common wisdom is that in five years medicine will be thoroughly enmeshed in a network of a few competing corporations and the individual practitioner will be a species endangered by extinction. Survival will be limited to those individuals who have "vertically integrated" every economic aspect of their practices with hospitals and other physicians in order to keep costs minimized and operations streamlined. Fortunately, common wisdom is usually wrong, but we are in a transition period.

Pacification, immobility, and intellectual catatonia are prescriptions for disaster. Jousting with bureaucrats through the judicial process is expensive and has been proven rather fruitless in the past. We certainly lack sympathy from state and national legislative bodies, and lobbying will not stave off the disaster that confronts us. Also, none of these responses are appropriate. What are we to do?

We need to appeal to our natural constituency — our patients. We need to enlist THEM as our allies in our efforts to prevent the disassemblage of American medicine. Recent studies[2-3] have shown that about 60% of patients do not want to have their current doctor-patient relationship disturbed; 85% are not bothered by the increased percentage of the gross national product that medical expenditures consume, and 75% of patients are happy with their medical care. We need to capitalize upon this favorable public opinion. We need to educate our patients about the consequences, turmoil and changes that currently beset medicine. The entire citizenry of this country does belong now or will belong in the future to some subset of our patient population. They all consume medical care, and ultimately the well-being of the medical care system will influence them as much as it influences us.

Education of our patients will require marketing skills. The competitive advertising we now see appearing in the media for hospitals, clinics and physicians is not the type of marketing we need, and such advertising abrades the professional sensitivities of most of us. We, however, can use the media in a dignified fashion. We can inform the general public of the advantages and disadvantages of HMOs, PPOs and IPAs. We can make known to the public our concerns about capitation-type reimbursement schedules, curtailment of medical research, the disadvantages of personal DRGs and the consequences of limiting access to medical technology. Since we also are embroiled in economic fomentation, we need to communicate in economic terms by reminding them of the economic benefits they derive from the medical care we give. When we communicate, we usually stress the humane facets and outcome of medical care, now we must stress the positive economic side of health care.

The capriciousness of the marketplace and politics never would have permitted the longterm commitment to excellence that has given us the medical advances of the past 40 years. It is extraordinarily important that we as physicians rescue American medicine from its threatened control by bureaucrats, accountants and boards of directors. Decisions concerning the allocations of resources, the quality of research and development, and the ap-

plication of technology must be maintained as the preserve of the physicians. We should allow experts in these other fields to inject their expertise into our decision processing, but the final responsibility for the health care of this nation must rest with its physicians.

The disadvantage we have as physicians is that most of us are ill-informed and unable to communicate with our patients on any of these matters. Our medical society leaders are not marketing experts. The messages we wish to transmit must be derived from data that are not readily available. The purpose of this new series of articles on medical economics is to explore these various issues and critically examine major changes that are erupting (such as alternative health care delivery systems, individual DRGs, the MESH concept, the control of medicine by government insurance and retailing companies). Hopefully from this exploration will emerge new strategies for the direction of health care — strategies that can preserve the excellent and jettison the wasteful within the present system, fertilize the imagination of the readers and spawn new ideas which will eradicate our current malaise, and inspire the Florida Medical Association to nurture and foster these ideas and provide an experimental milieu for their trial and development.

George Bernard Shaw stated, "The reasonable man adapts himself to the world; the unreasonable one persists in trying to adapt the world to himself. Therefore, all progress depends on the unreasonable man." Perhaps we need to be more unreasonable.

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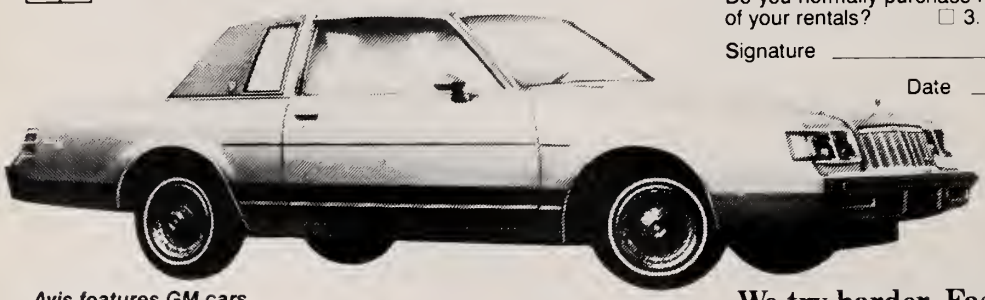
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Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

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Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

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DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structure infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h). For dosage recommendations in patients with impaired renal function, consult package insert.

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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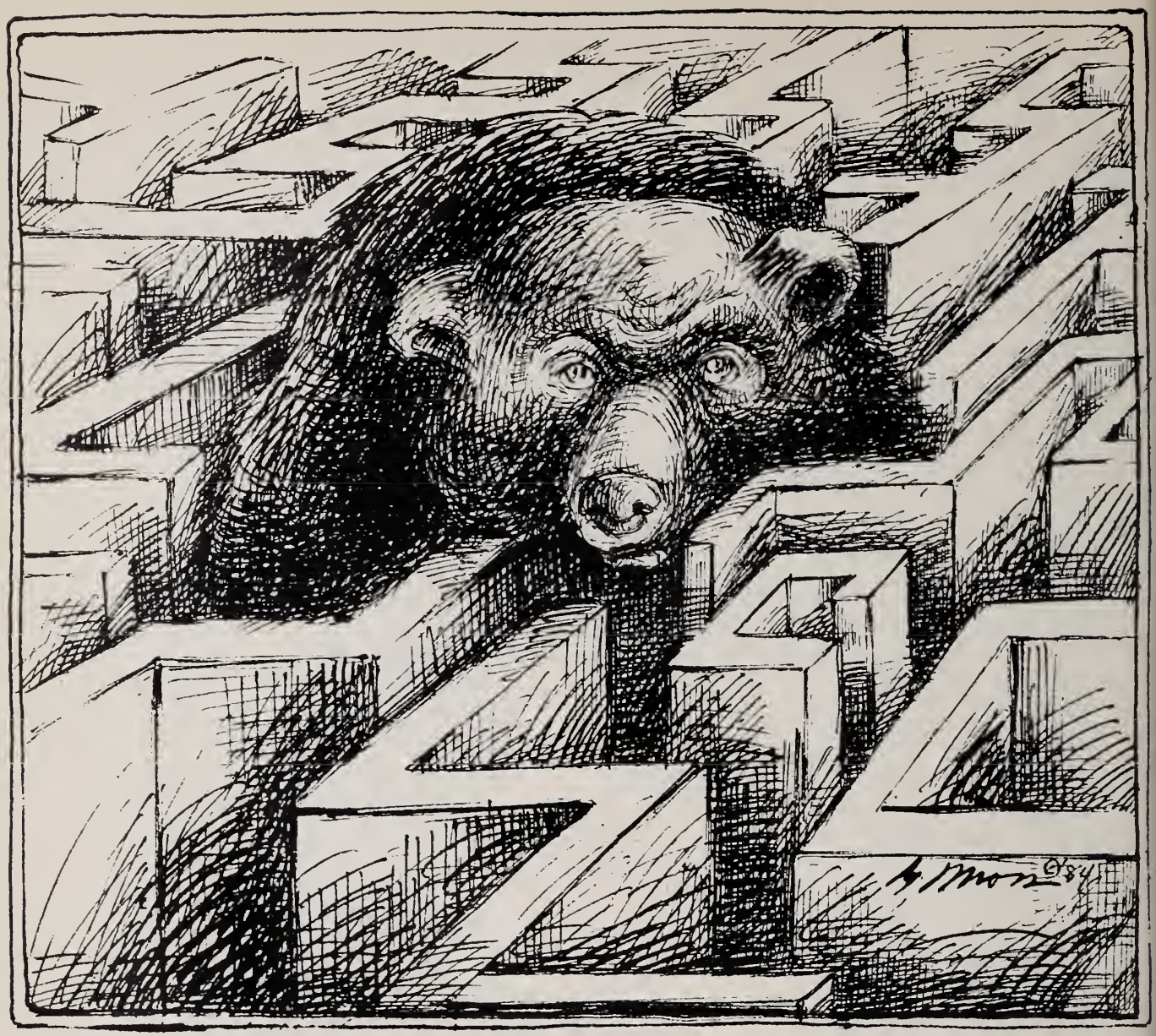
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NOTES & NEWS

Dr. Schiebler to fill new leadership role at UF's Health Science Center

Gerold L. Schiebler, M.D., has been appointed to the newly created position of Associate Vice President for Health Affairs for External Relations at the University of Florida's Health Science Center, Dr. David R. Challoner, UF Vice President for Health Affairs announced May 28



Dr. Schiebler

Dr. Challoner explained that the position, which will become effective by October 1, will include overseeing "our important activities in Jacksonville, such as the health center's expanding affiliation with University Hospital and our many projects in the Jacksonville health Education Program (JHEP)." He further explained that Dr. Schiebler will work with UF's Office of Government Relations in serving as the Health Science Center's primary liaison with the various branches of state government, including the Legislature and the Department of Health and Rehabilitative Services.

A specialist in pediatric cardiology and a UF medical faculty member since 1960, Dr. Schiebler has chaired the College of Medicine's Department of Pediatrics for 17 years and has served 10 consecutive years in a government relations role for the Health Science Center. Taking a year's leave of absence, he served in 1973-74 as Director of the newly formed Division of Children's Medical Services, a major component of HRS, and he has continued to work closely with that government agency in the development of state-supported programs for infants, children and their families.

Richard G. Connar, M.D. named USF Vice President for Medical Affairs

Richard G. Connar, M.D. has been named Vice President for Medical Affairs at the University of South Florida. He will serve as the Chief Administrative Officer for the USF Medical Center undertaking the administrative responsibility for all on and off-campus affiliated programs, which include, among others, the College of Medicine, the College of Nursing, the Shriners' Hospital for Crippled Children Tampa unit, the Southwest Florida Blood Bank, Inc., and the Eye Institute and the Kiwanis Children's Clinic.

Dr. Connar succeeds Andor Szentivanyi as Vice President, who will continue to serve as the Dean of the College of Medicine and will assume the title of Deputy Vice President for Medical Affairs.

Dr. Connar, a graduate of the Duke University Medical School, served as an assistant professor of surgery at that school before moving to Tampa in 1955 to begin his practice in thoracic and cardiovascular surgery. He affiliated with the University of South Florida College of Medicine in 1968. He was named professor and chairman of the department of surgery and president of the University Medical Services Association in 1982, and in 1984 he was named Deputy Vice President for Medical Affairs. Dr. Connar is a member of the Liaison Committee on Medical Education and is listed in *Who's Who in America*. He is a past president of the Hillsborough County Medical Association, as well as the Florida chapter of the American College of Surgeons, the Florida Society of Thoracic and Cardiovascular Surgeons and the Florida Thoracic Society.

AAFP offers new service to help family doctors find practice locations

A new service designed to help put family physicians in contact with practice opportunities has been instituted by the American Academy of Family Physicians (AAFP).

Computer-assisted Site Selection (COMPASS) is a clearinghouse for information exchange between practice-seeking family physicians and "opportunities" (physicians, communities, hospitals and others who are seeking a physician to join, buy or start a practice).

The COMPASS information bank is developed by means of two questionnaires. One goes to family physicians to elicit information on their practice

preferences. The other goes to opportunities to get information on what they offer. Periodic searches then will put family physicians and opportunities together. Family physicians will receive the questionnaires of opportunities that best fit their preference. Similarly, opportunities will receive family physicians' questionnaires, unless the family physicians wish otherwise. Physicians and opportunities follow up directly with one another.

COMPASS is free for AAFP members looking for practice locations. Opportunities are charged according to the following fee schedule: (1) AAFP members looking for someone to join or buy their practice — $175 per year; (2) Non-members (physicians, hospitals, communities, etc.) — $225 per year; (3) For-profit search firms — $600 per year. All opportunities pay $150 for each additional position listed.

Additional information may be obtained by writing COMPASS, AAFP headquarters, 1740 W. 92nd Street, Kansas City, Missouri 64114.

The AAFP is the national organization for family physicians, representing more than 57,000 family doctors and medical students.

AMA publishes current list of self-designated practice specialties

The Division of Survey and Data Resources of the American Medical Association has published the following list of codes for *self-designated* practice specialties:

ADL — Adolescent Medicine
AM — Aerospace Medicine
A — Allergy
AI — Allergy and Immunology
AN — Anesthesiology
CD — Cardiovascular Diseases
CCM — Critical Care Medicine
D — Dermatology
DMP — Dermatopathology
DIA — Diabetes
DLI — Diagnostic Laboratory Immunology
EM — Emergency Medicine
END — Endocrinology
FP — Family Practice
GE — Gastroenterology
GP — General Practice
GPM — General Preventive Medicine
GER — Geriatrics
GO — Gynecological Oncology
GYN — Gynecology
HEM — Hematology
IG — Immunology
IP — Immunopathology
ID — Infectious Diseases
LM — Legal Medicine
IM — Internal Medicine
MFM — Maternal and Fetal Medicine
MM — Medical Microbiology
NPM — Neonatal—Perinatal Medicine
NEP — Nephrology
N — Neurology
CHN — Neurology, Child
NA — Neuropathology
NM — Nuclear Medicine
NR — Nuclear Radiology
NTR — Nutrition
OBS — Obstetrics
OBG — Obstetrics and Gynecology
OM — Occupational Medicine
ON — Oncology
OPH — Ophthalmology
OTO — Otolaryngology
OFS — Otolaryngological Facial Plastic Surgery
PTH — Pathology, Anatomic/Clinical
ATP — Pathology, Anatomic
BLB — Pathology, Blood Banking
CMP — Pathology, Chemical
CLP — Pathology, Clinical
FOP — Pathology, Forensic
RIP — Pathology, Radioisotopic
PD — Pediatrics
PDA — Pediatric Allergy
PDC — Pediatric Cardiology
PDE — Pediatric Endocrinology
PHO — Pediatric Hematology—Oncology
PNP — Pediatric Nephrology
PA — Pharmacology, Clinical
PM — Physical Medicine and Rehabilitation
P — Psychiatry
CHP — Psychiatry, Child
PYA — Psychoanalysis
PH — Public Health
PUD — Pulmonary Diseases
R — Radiology
DR — Radiology, Diagnostic
PDR — Radiology, Pediatric
TR — Radiology, Therapeutic

REN — Reproductive Endocrinology
RHU — Rheumatology
ABS — Surgery, Abdominal
CDS — Surgery, Cardiovascular
CRS — Surgery, Colon and Rectal
GS — Surgery, General
HS — Surgery, Hand
HNS — Surgery, Head and Neck
NS — Surgery, Neurological
ORS — Surgery, Orthopedic
PDS — Surgery, Pediatric
PS — Surgery, Plastic
TS — Surgery, Thoracic
TRS — Surgery, Traumatic
U — Surgery, Urological
VS — Surgery, Vascular

In addition to the above, the following specialty designations are also used:

OS — Other, i.e., a specialty other than those appearing above
US — Unspecified specialty

DEAN'S MESSAGE

In vitro fertilization and embryo transfer: new horizon in treatment of infertility at the University of Miami School of Medicine

A healthy baby girl born on the 4th of last April, in Boynton Beach, was the first infant in Florida to be successfully conceived through the In-Vitro Fertilization and Embryo Transfer Program (IVF-ET) at the University of Miami School of Medicine. This complex procedure required the concerted team approach of University physicians from the Division of Reproductive Endocrinology, the Division of Diagnostic Ultrasound, the Department of Anesthesiology, and the Ambulatory Surgical Pavilion at Highland Park General Hospital in Miami.

To be eligible for the IVF-ET program, the couple must be married and under 40 years of age. If the wife has severely damaged or absent fallopian tubes, if the husband suffers from oligospermia which has not responded to traditional treatment, or if the cause of infertility cannot be determined but has failed to respond to conventional therapy for more than two years, the couple will be considered candidates for this procedure.

The human IVF-ET process involves several steps. Currently, ovarian hyperstimulation is induced with several different types of medications. Protocols most commonly used are clomiphene citrate in dose of 150 mg/day and variable doses of human menopausal gonadotropins (Pergonal). This hyperstimulation encourages the development of multiple oocytes, which are recovered by laparoscopy for fertilization in vitro.

The response to stimulation is monitored primarily by serum estradiol measurement. Daily real-time ultrasounds are utilized to determine follicular growth parameters, the number of follicles developing, and the time of ovulation initiation. The results of these determinations are correlated to judge the response to stimulation and the time of follicle maturation.

Laparoscopy for oocyte retrieval is performed under general anesthesia with a specifically designed oocyte collection system. Follicular fluid scanning is performed very rapidly for identification and staging of the maturity of the collected oocytes in a specially-designed tissue culture laboratory near the operating suite. This laboratory is used for oocyte identification, oocyte culturing, sperm washing, and insemination. Over a 40-hour period, oocyte-embryo culturing is performed resulting in the development of the early conceptus. Within 40-48 hours after oocyte collection, the embryo is transferred by transcervical route back into the oocyte donor. This is done without an anesthetic. The patient is then maintained at rest for a variable period of time, usually less than 24 hours, after which she is discharged.

Due to the possibility of luteal phase inadequacy from ovarian hyperstimulation, the patient may be given progesterone for approximately ten days after the embryo transfer. After that, serum B-HCG radioimmunoassay is performed to detect early implantation and pregnancy. If the woman becomes pregnant, she will be referred back to her obstetrician for prenatal care.

As of April of this year, approximately 50 laparoscopies for oocyte retrieval have been performed, resulting in the transfer of one or more eggs in approximately 40 patients. To date, this has resulted in a total of seven pregnancies, four of which were terminated by spontaneous abortions. The fifth pregnancy has been delivered uneventfully at term. Delivery of two more pregnancies is expected sometime this summer.

Currently, IVF-ET is a clinically applicable procedure and no longer considered purely experimental. Worldwide, the IVF-ET pregnancy rate has shown a steady increase since its first conception in 1978.

With future scientific breakthrough, it is of little doubt that the success rate may some day surpass the natural conception rate which has been estimated at approximately 25 percent.

Oscar Davidson, M.D.
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Department of Ob/Gyn
Bernard J. Fogel, M.D.
Vice President for
Medical Affairs, and Dean
Tran T. Hung, M.D.
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Division of Reproductive
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ENCORES!

Are charges too high?

From 1980 through 1984, the Consumer Price Index for all items rose 6.5%. In the same period, physicians services rose 9.2%. In 1984 alone, the CPI rose only 4.0% but physicians services rose 6.0%.

What does this mean? To a large extent, it means just what it looks like it means. Many doctors are staying well ahead of inflation in their incomes, and, in fact, are going from rich to richer when compared to their fellow citizens.

As we see the growing tide of change all about us in the way medicine is practiced in America, we cannot help but realize that the ultimate aim of every new plan that is being tried is to decrease the amount of money being spent for medical care. This necessarily must mean a decrease in the amount ultimately going to providers of such care. The government agencies, business coalitions and insurance groups who are pushing for cost cutting are willing to look at almost any possible method to decrease their medical costs.

They will try almost any group which presents itself as a cheap alternative to physicians — witness the spreading acceptance of nurse practitioners, the increasing clout of chiropractors trying to force their way onto hospital staffs and of optometrists trying to prescribe drugs. There now even appears to be a strong possibility of Florida's pharmacists being given the right to prescribe.

When it comes to dealing with real doctors, every conceivable method is being tried to lower the costs — with HMOs, PPOs, IPAs, price freezes, etc. — and more ideas are on the way.

Basically physicians have responded to these pressures in two ways. Most have reacted with howls of indignation. They have found themselves caught between the conflicting forces of their concern for their patients welfare, their justifiable desire for adequate compensation, and the increasing storm of criticism aimed at all physicians as being greedy and self-serving in a time of health cost crisis. Most physicians actually do want to provide the best possible care for their patients. They fear the dangers of patients being treated by grossly underqualified "alternative health care providers". They reject the idea of health care rationing that treats statistical groups rather than individuals who are in need of help. They feel that anyone who goes through 15 to 20 years of school and post graduate education and then makes himself available to others for periods of 120 hours a week or more deserves a better than average income. And they are hurt by the abuse of those outside our profession who attack us.

At the same time, however, there are a few of us who have reacted differently. There is a growing minority of physicians who have responded by trying to gouge the system for everything it is worth — often with the professed intention of "getting their share" before the system, collapses entirely. They are like squirrels, hoarding nuts before winter comes. They set their prices far beyond the going rates so as to establish a high profile. They respond to price freezes by redefining routine care as being suddenly more intense (and, therefore, more expensive) and by performing an ever-increasing number of extra "services" for an extra price and, in some cases, there seems to be no limit to how far such methods can be stretched. Routine patient complaints that were handled on the telephone for free or in the office for $5.00 to $10.00 just a few years ago now precipitate a complete physical and laboratory work-up for $100.00 to $150.00. Routine care that was always considered a part of the fixed rate for a patient visit has now become a separate charge and is more than the visit used to cost.

Such methods have been successful. Many physicians are becoming quite wealthy with them. It is because of such physicians, however, that the rest of us are taking so much heat.

Perhaps it is time for the rest of us to recognize this division in our ranks. It appears that alternative methods of financing medical care will be the reality of the future. If we work for fair compensation and a mechanism to continue giving quality care, then

there is still a chance that those who pay the bills will accept our input and work with us to mold a workable system. We must realize, however, that "fair" compensation implies "not too much" just as much as it implies "not too little". Some physicians are going to have to have their gold mines closed and, if we are to preserve medicine's good name and provide quality care with the available money, then we need to help close them.

The Federal Trade Commission has made it a crime for organized medicine to prevent individual physicians from overcharging. Some physicians do overcharge, however, and we should enter this new age of medical financing schemes content to have them fall by the wayside if they are intent on that course.

Henry L. Harrell Jr., M.D.
Editor
The Bulletin of the Marion County Medical Society
Ocala

Reprinted with permission from the *Bulletin* of the Marion County Medical Society, April 1985.

Confronting the pied pipers of sex

Over the last 25 years, society has witnessed a dramatic change in sexual mores. One would be hard-pressed to think of any sexual activity or behavior that is proscribed, and what in the past would have been labeled unredeemable trash has found social acceptance and a safe haven in the classrooms of medical schools.

This overturning of traditional morality has been called a sexual revolution. From its beginnings, it was engineered by a select group of medical professionals — including Dr. Mary Calderone, who founded the Sex Information and Education Council of the U.S., and Dr. William H. Masters. Out of proportion to their individual contributions, they have had an astonishing impact on society and all its institutions. Rather than owe gratitude to these entrepreneurs of sexuality, we need to diminish their influence by promoting a sane and balanced position with regard to sexual behavior and public health protection.

The unleashing of the full fury of the sexual revolution has not yet produced any measurable benefits to the country as a whole — unless we think in terms of monetary gain. But with its emphasis on sex as a recreation and a spectator sport, the revolution has produced a host of problems that threaten us with social chaos — venereal disease for one. VD is not a new scourge, but it has now become a plague, giving rise to new strains of exotic bacteria and virus-like agents. Genital herpes, incurable in adults, has caused infant deaths from meningoencephalitis. AIDS, which was once limited to segments of the homosexual community and certain Third World countries, has found its way into the mainstream of our society and into the bloodstreams of innocent victims via contaminated donor blood.

The mounting evidence indicting the leaders of the sexual revolution is impressive. They promised joy, liberation, and good health. They've delivered misery, disease, and even death.

Besides the plague of venereal infections and other sexual ailments, society has had to face the tragic realities of teenage pregnancies, teenage abortions, incest, kiddy porn, and an ever-increasing divorce rate. Though we can't produce a statistical link between the sexual revolution and these problems, it's undeniable that the "health-giving" benefits of promiscuity are nowhere to be seen.

Perhaps, too, we cannot lay the entire blame for the deteriorating mental health statistics at the feet of the revolutionaries. But if there were as many benefits as were promised, why should there be such a surge of teenage suicides? In the last two decades, the rate has doubled. Alcoholism and drug abuse have increased dramatically in the same age group over the same period. The ever-rising misery index is hardly a testimony to mental and physical benefits the entrepreneurs promised. In fact, we might conclude that casual sex is about the most dangerous game around.

It would be naive to suggest we can change things back to the way they were. Censorship and repression don't lend themselves to being suitable tools with which to mount a counterrevolution. And if the professional's attitude is that the young are intractably hooked on the sexual revolution, what can anyone do?

The answer is that we must recognize that the appeal for a change to responsible behavior has to start at the top levels — people in leadership positions in law, medicine, psychology, and the advertising and entertainment media. If the sexual entrepreneurs have made incredible progress in overturning traditional morality, it's because a large segment of professional leaders have assisted while another, even larger segment has stood aside and watched it happen. This latter group is the one that now must discard its apathy, get involved, and present the young with a better vision of the future, consistent with sexual responsibility and based on truth.

Alexandra Mark, Ph.D., and
Vernon H. Mark, M.D.
Boston, Massachusetts

Reprinted with permission from *Medical World News*, April 8, 1985, page 156.

CORRESPONDENCE

Improving care for indigents

Dear Editor: This is a proposal to improve medical care for the indigent and to lessen the burden on those physicians who render such care. Historically states and communities have seldom provided adequate funding for medical care of indigent people and the onus is borne principally by physicians and community hospitals. The problem has been exacerbated by recent cut-backs in federal spending, regional massive immigrations to the U.S., and by other factors. Briefly stated, this proposal is (1) to encourage physicians to provide care to the indigent without any fee, (2) allow the physicians to document their services as now done in charging for services and (3) the amounts of those services would then be deductible from federal income taxes. This idea has been suggested for a long time, but because implementation requires national legislation in coordination with local management, there has been no concerted legislative effort to accomplish it. However, as medical care has become expensive and providing care for the indigent is such a problem, the

The care of the medical indigent in many community hospitals falls on the shoulders of the physicians just entering practice and is often a requirement of staff membership, at least during their first years. Our proposal would make tax deductions attractive enough for some of the senior members of hospital staffs to continue in care of the indigents.

With many doctors participating in the program, concern about possible increase in medical liability problems would probably not be a valid fear. Also, the money saved in taxes might well off-set the premiums already being paid to insurance companies.

If professional services to the indigent become tax-deductible, then this same idea can encourage those in other professionals to aid the indigent. In the legal profession a similar idea is expressed by Robert J. Derham of Ft. Lauderdale writing in the Florida Bar Journal: "In criminal law the indigent defendant is forced to accept the overworked, underpaid public defender assigned to him and, the public is forced to accept plea bargains made necessary for the overworked, underpaid prosecutors. Meanwhile, in private practice there is a pool of attorneys able to provide legal representation to the accused indigent and able to devote the required prosecution effort to give the public its day in court. The public defender's office and the prosecution office could provide administrative and staff services overseeing the conduct of the chosen private attorneys, and the amount of the tax deduction 'fee' would be determined in court after an evidentiary hearing, as is the custom today.

"Enactment of tax deductibility of the fair value of litigation services rendered the poor is, of course, a matter for the United States Congress. I recognize that the ABA is a more effective lobby for such legislation than the Florida Bar, but the effort must start somewhere. The bar associations must have the "guts" to tell the American people that they cannot expect something for nothing. The "privilege" of a pilot license does not impose a duty to transport by air those who cannot pay. Each is examined and licensed for the protection of the public. A forced client (mandatory pro bono) is no better than a forced attorney (legal aid/public defender); both violate the basic tenet of the traditional client/attorney relationship, i.e., mutual free choice..."

The above arguments apply equally well to physicians providing free care to the needy. So to get this accomplished, legislative action at the national level will be required and perhaps some enabling legislation within the states, nation-wide. Why not instruct our AMA Delegates from the State of Florida to work toward getting this as one of our congressional legislative goals on the national scene? This could be one area where physicians and attorneys can lobby together for the common good.

David S. Hubbell, M.D.
St. Petersburg

SCAM OF THE MONTH

Editor's Note: The "Scam of the Month" project was undertaken by the Missouri Task Force on Misuse, Abuse and Diversion of Prescription Drugs as part of an effort to improve professional and law enforcement awareness of some of the tricks used by abusers and others to divert prescription drugs to street and other inappropriate use. While the vignettes in this series actually occurred in Missouri, they could occur in Florida and may well have already. We convey our thanks to the Missouri Task Force for sharing this series with us.

"I'm an addict, help me scam"

Several professional drug dealers use this scam to obtain large quantities of DILAUDID, the most highly abused Schedule II narcotic in Missouri.

The patient will unexpectedly arrive at a physician's office (psychiatrists are primary targets) and confess that he (she) is a narcotic addict. The patient will then request the assistance of the physician in

getting straight and will usually tell the physician how many tablets of 4 mg DILAUDID he (she) is taking a day.

The patient will con the physician into prescribing DILAUDID on a regular basis, from every other day to once a week (of course the prescriptions given once a week have to be for at least 100 DILAUDID 4 mg). Investigations of cases involving two of the most notorious drug dealers in Missouri indicate they were obtaining over 1,000 4 mg DILAUDID tablets on a weekly basis. One of these individuals was seeing over 75 physicians on a rotating basis. An estimate of the money made by this individual in a three year period from the sale of the DILAUDID he obtained was approximately three quarters of a million dollars ($750,000.00). He has since been shot to death in another state.

Caution • Physicians should be aware that the Code of Federal Regulations prohibits the prescribing of any Controlled Drug for the detoxification or maintenance of a person addicted to narcotics. Persons addicted to narcotics must be enrolled in an approved Narcotic Treatment Program (NTP PROGRAM) where they can be properly monitored and supervised.

For more information concerning NTP Programs contact the Missouri Bureau of Narcotics and Dangerous Drugs or either office of the Drug Enforcement Administration in St. Louis or Kansas City.

American Diabetes Association

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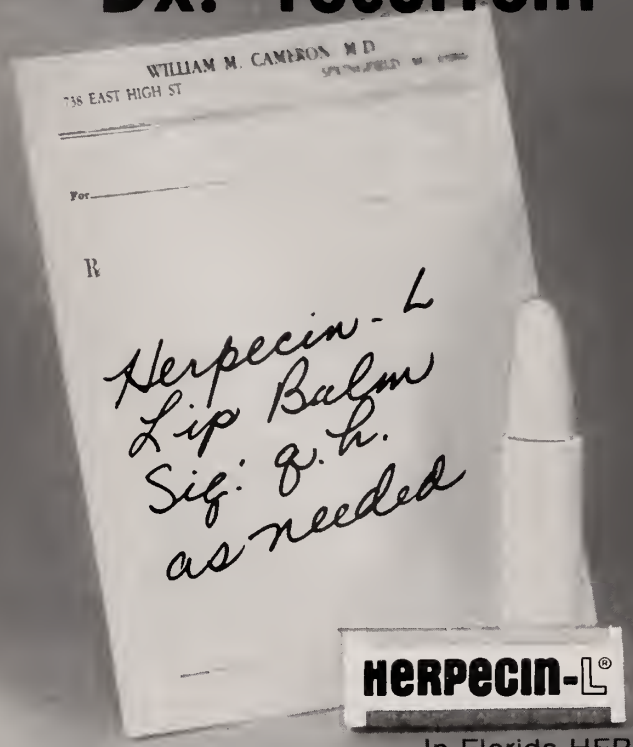
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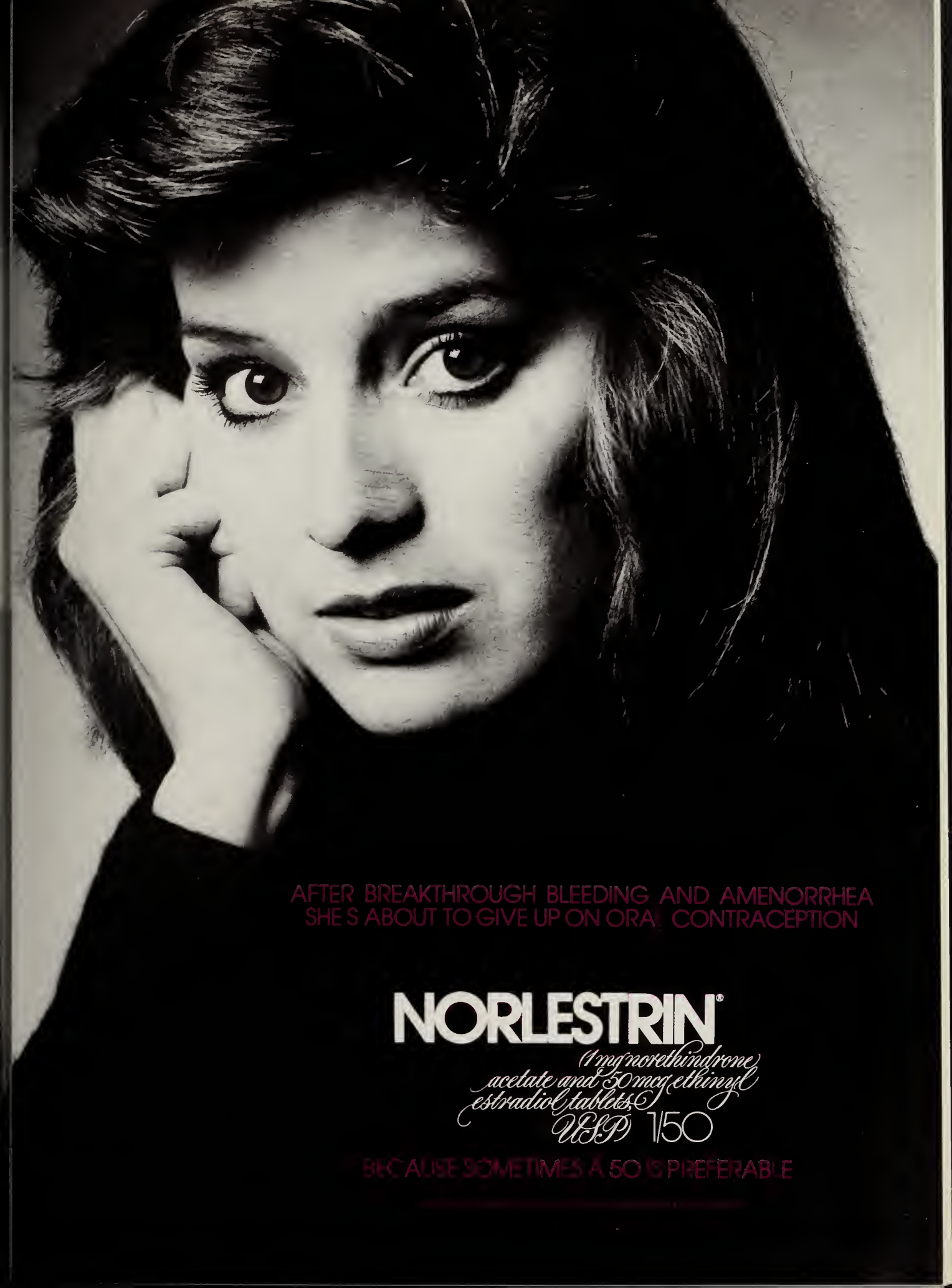
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Brief Summary of Prescribing Information
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See section under **Special Notes on Administration and HOW SUPPLIED.**
Before prescribing, please see full prescribing information. A Brief Summary follows.

DESCRIPTION
Norlestrin Products are progestogen-estrogen combinations.

INDICATIONS AND USAGE
Norlestrin Products are indicated for the prevention of pregnancy in women who elect to use oral contraceptives as a method of contraception.

In clinical trials with Norlestrin 1/50 involving 25,983 therapy cycles, there was a pregnancy rate of 0.05 per 100 woman-years; in clinical trials with Norlestrin 2.5/50 involving 96,388 cycles, there was a pregnancy rate of 0.22 per 100 woman-years.

Dose-Related Risk of Thromboembolism from Oral Contraceptives: Studies have shown a positive association between the dose of estrogens in oral contraceptives and the risk of thromboembolism. It is prudent and in keeping with good principles of therapeutics to minimize exposure to estrogen. The oral contraceptive prescribed for any given patient should be that product which contains the least amount of estrogen that is compatible with an acceptable pregnancy rate and patient acceptance.

CONTRAINDICATIONS
1. Thrombophlebitis or thromboembolic disorders.
2. A past history of deep-vein thrombophlebitis or thromboembolic disorders.
3. Cerebral vascular or coronary artery disease.
4. Known or suspected carcinoma of the breast.
5. Known or suspected estrogen-dependent neoplasia.
6. Undiagnosed abnormal genital bleeding.
7. Known or suspected pregnancy. (See WARNING No. 5.)
8. Benign or malignant liver tumor which developed during the use of oral contraceptives or other estrogen-containing products.

WARNINGS

Cigarette smoking increases the risk of serious cardiovascular side effects from oral contraceptive use. The risk increases with age and with heavy smoking (15 or more cigarettes per day) and is quite marked in women over 35 years of age. Women who use oral contraceptives should be strongly advised not to smoke.

The use of oral contraceptives is associated with increased risk of several serious conditions including thromboembolism, stroke, myocardial infarction, hepatic adenoma, gallbladder disease, and hypertension. Practitioners prescribing oral contraceptives should be familiar with the following information relating to these risks.

1. *Thromboembolic Disorders and Other Vascular Problems.* An increased risk of thromboembolic and thrombotic disease associated with the use of oral contraceptives is well-established. Studies have demonstrated an increased risk of fatal and nonfatal venous thromboembolism and stroke, both hemorrhagic and thrombotic.

Cerebrovascular Disorders: In a collaborative study in women with and without predisposing causes, it was estimated that the risk of hemorrhagic stroke was 2.0 times greater in users than nonusers, and the risk of thrombotic stroke was 4.0 to 9.5 times greater.

Myocardial Infarction: An increased risk of myocardial infarction associated with oral contraceptives has been reported confirming a previously suspected association. These studies found that the greater the number of underlying risk factors (cigarette smoking, hypertension, hypercholesterolemia, obesity, diabetes, history of preeclamptic toxemia) for coronary artery disease, the higher the risk of developing myocardial infarction, regardless of whether the patient was an oral contraceptive user or not. Oral contraceptives, however, were found to be a clear additional risk factor.

It has been estimated that users who do not smoke (smoking is considered a major predisposing condition to myocardial infarction) are about twice as likely to have a fatal myocardial infarction as nonusers who do not smoke. Oral contraceptive users who are smokers have about a fivefold increased risk of fatal infarction compared to users who do not smoke, but about a tenfold to twelvefold increased risk compared to nonusers who do not smoke. The amount of smoking is also an important factor.

Risk of Dose: In an analysis of data, British investigators concluded that the risk of thromboembolism, including coronary thrombosis, is directly related to the dose of estrogen used in oral contraceptives, however, the quantity of estrogen may not be the sole factor involved.

Persistence of Risk: Two studies have suggested that an increased risk may persist for as long as 6 years after discontinuation of oral contraceptive use for cerebrovascular disease and 9 years for myocardial infarction. In addition, a prospective study suggested the persistence of risk for subarachnoid hemorrhage.

Estimate of Excess Mortality from Circulatory Diseases: The risk of diseases of the circulatory system is concentrated in older women, in those with a long duration of use, and in cigarette smokers.

A study of available data from a variety of sources concluded that the mortality associated with all methods of birth control is low and below that associated with childbirth, with the exception of oral contraceptives in women over 40 who smoke.

The risk of thromboembolic and thrombotic diseases associated with oral contraceptives increases with age after approximately age 30 and, for myocardial infarction, is further increased by hypertension, hypercholesterolemia, obesity, diabetes, or history of preeclamptic toxemia, and especially by cigarette smoking.

The physician and the patient should be alert to the earliest manifestations of thromboembolic and thrombotic disorders. Should any occur or be suspected, the drug should be discontinued immediately.

A fourfold to sixfold increased risk of postsurgery thromboembolic complications has been reported in users. If feasible, oral contraceptives should be discontinued at least four weeks before surgery of a type associated with an increased risk of thromboembolism or prolonged immobilization.

2. *Ocular Lesions.* Neuro-ocular lesions, such as optic neuritis or retinal thrombosis, have been associated with the use of oral contraceptives. Discontinue the oral contraceptive if there is unexplained sudden or gradual, partial or complete loss of vision, onset of proptosis or diplopia; papilledema or retinal vascular lesions.

3. *Carcinoma.* Long-term continuous administration of estrogen in certain animal species increases the frequency of carcinoma of the breast, cervix, vagina, and liver.

In humans, an increased risk of endometrial carcinoma associated with the prolonged use of exogenous estrogen in postmenopausal women has been reported. However, there is no evidence suggesting increased risk of endometrial cancer in users of conventional combination or progestogen-only oral contraceptives.

Studies found no evidence of increase in breast cancer in women taking oral contraceptives, however, an excess risk in users with documented benign breast disease was reported.

There is no confirmed evidence of an increased risk of cancer associated with oral contraceptives. Close clinical surveillance of users is, nevertheless, essential. In cases of undiagnosed persistent or recurrent abnormal vaginal bleeding, appropriate diagnostic measures should be taken to rule out malignancy. Women with a strong family history of breast cancer, or who have breast nodules, fibrocystic disease, or abnormal mammograms, should be monitored with particular care.

4. *Hepatic Tumors.* Benign hepatic adenomas have been found to be associated with oral contraceptives. Because hepatic adenomas may rupture and may cause death through intra-abdominal hemorrhage, they should be considered in women presenting abdominal pain and tenderness, abdominal mass, or shock.

A few cases of hepatocellular carcinoma have been reported in women taking oral contraceptives. The relationship of these drugs to this type of malignancy is not known at this time.

5. *Usage in or Immediately Preceding Pregnancy. Birth Defects in Offspring, and Malignancy in Female Offspring.* During early pregnancy, female sex hormones may seriously damage the offspring.

An increased risk of congenital anomalies, including heart defects and limb defects, has been reported with the use of oral contraceptives in pregnancy.

There is some evidence that triploidy and possible other types of polyploidy are increased among abortuses from women who become pregnant soon after ceasing oral contraceptives.

Pregnancy should be ruled out before continuing an oral contraceptive in any patient who has missed two consecutive menstrual periods. If the patient has not adhered to the schedule, the possibility of pregnancy should be considered at the time of the first missed period, and oral contraceptives should be withheld until pregnancy has been ruled out. If pregnancy is confirmed, the patient should be apprised of the potential risks to the fetus and the advisability of continuation of the pregnancy should be discussed.

Women who discontinue oral contraceptives with the intent of becoming pregnant should use an alternate form of contraception for a period of time before attempting to conceive.

Administration of progestogen-only or progestogen-estrogen combinations to induce withdrawal bleeding should not be used as a test of pregnancy.

6. *Gallbladder Disease.* Studies report an increased risk of surgically confirmed gallbladder disease in users of oral contraceptives.

7. *Carbohydrate and Lipid Metabolic Effects.* Because decreased glucose tolerance has been observed in a significant percentage of patients, prediabetic and diabetic patients should be carefully observed while receiving oral contraceptives.

An increase in triglycerides and total phospholipids has been observed.

8. *Elevated Blood Pressure.* An increase in blood pressure has been reported in patients receiving oral contraceptives. The prevalence in users increases with longer exposure. Age is also strongly correlated with development of hypertension. Women who previously have had hypertension during pregnancy may be more likely to develop elevation of blood pressure.

9. *Headache.* Onset or exacerbation of migraine or development of headache of a new pattern which is recurrent, persistent, or severe, requires discontinuation of oral contraceptives.

10. *Bleeding Irregularities.* Breakthrough bleeding, spotting, and amenorrhea are frequent reasons for patients discontinuing oral contraceptives. In breakthrough bleeding, nonfunctional causes should be borne in mind. In undiagnosed abnormal bleeding from the vagina, adequate diagnostic measures are indicated to rule out pregnancy or malignancy.

Women with a past history of oligomenorrhea or secondary amenorrhea, or young women without regular cycles should be advised that they may have a tendency to remain anovulatory or to become amenorrheic after discontinuation of oral contraceptives.

11. *Ectopic Pregnancy.* Ectopic as well as intrauterine pregnancy may occur in contraceptive failures.

12. *Breast-Feeding.* Oral contraceptives may interfere with lactation. Furthermore, a small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs.

PRECAUTIONS
1. A complete medical and family history should be taken prior to the initiation of oral contraceptives. The pretreatment and periodic physical examinations should include special reference to blood pressure, breasts, abdomen, and pelvic organs, including Papanicolaou smear and relevant laboratory tests. As a general rule, oral contraceptives should not be prescribed for longer than one year without another examination.
2. Preexisting uterine leiomyomata may increase in size.
3. Patients with a history of psychic depression should be carefully observed and the drug discontinued if depression recurs to a serious degree.
4. Oral contraceptives may cause fluid retention and should be prescribed with caution, and only with careful monitoring, in patients with conditions which might be aggravated.
5. Patients with a past history of jaundice during pregnancy have an increased risk of recurrence of jaundice. If jaundice develops, the medication should be discontinued.
6. Steroid hormones may be poorly metabolized and should be administered with caution in patients with impaired liver function.
7. Users may have disturbances in normal tryptophan metabolism, which may result in a relative pyridoxine deficiency.
8. Serum folate levels may be depressed.
9. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted.
10. Certain endocrine and liver function tests and blood components may be affected: (a) Increased sulfobromophthalein retention. (b) Increased prothrombin and factors VII, VIII, IX, and X; decreased antithrombin 3; increased norepinephrine-induced platelet aggregability. (c) Increased thyroid-binding globulin (TBG) leading to increased circulating total thyroid hormone. (d) Decreased pregnanediol excretion. (e) Reduced response to metyrapone test.

Drug Interactions: Reduced efficacy and increased incidence of breakthrough bleeding have been associated with concomitant use of rifampin. A similar association has been suggested with barbiturates, phenylbutazone, phenytoin sodium, tetracycline, and ampicillin.

ADVERSE REACTIONS
An increased risk of the following serious adverse reactions has been associated with oral contraceptives: thrombophlebitis; pulmonary embolism; coronary thrombosis, cerebral thrombosis, cerebral hemorrhage, hypertension; gallbladder disease; benign hepatomas, congenital anomalies.

There is evidence of an association between the following conditions and the use of oral contraceptives, although additional confirmatory studies are needed: mesenteric thrombosis, neuro-ocular lesions, eg, retinal thrombosis and optic neuritis.

The following adverse reactions have been reported in patients receiving oral contraceptives and are believed to be drug related: nausea and/or vomiting, usually the most common adverse reactions, occur in approximately 10% or less of patients during the first cycle. Other reactions, as a general rule, are seen much less frequently or only occasionally: gastrointestinal symptoms, breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea, amenorrhea during and after treatment; temporary infertility after discontinuance of treatment, edema; chloasma or melasma, breast changes, change in weight, change in cervical erosion and cervical secretion; possible diminution in lactation when given immediately postpartum, cholestatic jaundice; migraine, increase in size of uterine leiomyomata, rash (allergic), mental depression, reduced tolerance to carbohydrates, vaginal candidiasis, change in corneal curvature, intolerance to contact lenses.

The following adverse reactions have been reported and the association has been neither confirmed nor refuted: premenstrual-like syndrome, cataracts, changes in libido, chorea, changes in appetite; cystitis-like syndrome, headache, nervousness, dizziness, hirsutism, loss of scalp hair, erythema multiforme, erythema nodosum, hemorrhagic eruption, vaginitis, porphyria.

Special Notes on Administration
Menstruation usually begins two or three days, but may begin as late as the fourth or fifth day, after discontinuing medication.

After several months on treatment, bleeding may be reduced to a point of virtual absence; reduced flow may be a result of medication and not indicative of pregnancy.

HOW SUPPLIED
Norlestrin 21 1/50 is available in compacts each containing 21 tablets. Each tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin 21 2.5/50 is available in compacts each containing 21 tablets. Each tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

Norlestrin Fe 1/50 is available in compacts each containing 21 yellow tablets and 7 brown tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate. USP. Available in packages of five compacts and packages of five refills.

Norlestrin FE 2.5/50 is available in compacts each containing 21 pink tablets and 7 brown tablets. Each pink tablet contains 2.5 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Each brown tablet contains 75 mg of ferrous fumarate. USP. Available in packages of five compacts and packages of five refills.

Norlestrin 28 1/50 is available in compacts each containing 21 yellow tablets and 7 white inert tablets. Each yellow tablet contains 1 mg of norethindrone acetate and 50 mcg of ethinyl estradiol. Available in packages of five compacts and packages of five refills.

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PD-21-JA-2563-P-1(11-84)

BALANCED CALCIUM CHANNEL BLOCKADE!



Low incidence of side effects
CARDIZEM® (diltiazem HCl) produces an incidence of adverse reactions not greater than that reported with placebo therapy, thus contributing to the patient's sense of well-being.

*Cardizem is indicated in the treatment of angina pectoris due to coronary artery spasm and in the management of chronic stable angina (classic effort-associated angina) in patients who cannot tolerate therapy with beta-blockers and/or nitrates or who remain symptomatic despite adequate doses of these agents.

References:
1. Strauss WE, McIntyre KM, Parisi AF, et al: Safety and efficacy of diltiazem hydrochloride for the treatment of stable angina pectoris: Report of a cooperative clinical trial. Am J Cardiol 49:560-566, 1982.
2. Pool PE, Seagren SC, Bonanno JA, et al: The treatment of exercise-inducible chronic stable angina with diltiazem: Effect on treadmill exercise. Chest 78 (July suppl):234-238, 1980.

Reduces angina attack frequency*
42% to 46% decrease reported in multicenter study.[1]

Increases exercise tolerance*
In Bruce exercise test,[2] control patients averaged 8.0 minutes to onset of pain; Cardizem patients averaged 9.8 minutes ($P<.005$).

CARDIZEM®
(diltiazem HCl)

THE BALANCED CALCIUM CHANNEL BLOCKER

Please see full prescribing information on following page.

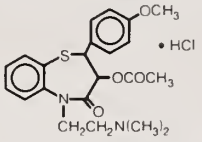
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PROFESSIONAL USE INFORMATION

cardizem®
(diltiazem HCl)
30 mg and 60 mg tablets

DESCRIPTION

CARDIZEM® (diltiazem hydrochloride) is a calcium ion influx inhibitor (slow channel blocker or calcium antagonist). Chemically, diltiazem hydrochloride is 1,5-Benzothiazepin-4(5H)one,3-(acetyloxy) -5-[2-(dimethylamino)ethyl]-2,3-dihydro-2-(4-methoxyphenyl)-, monohydrochloride,(+) -cis-. The chemical structure is:



Diltiazem hydrochloride is a white to off-white crystalline powder with a bitter taste. It is soluble in water, methanol, and chloroform. It has a molecular weight of 450.98. Each tablet of CARDIZEM contains either 30 mg or 60 mg diltiazem hydrochloride for oral administration.

CLINICAL PHARMACOLOGY

The therapeutic benefits achieved with CARDIZEM are believed to be related to its ability to inhibit the influx of calcium ions during membrane depolarization of cardiac and vascular smooth muscle.

Mechanisms of Action. Although precise mechanisms of its antianginal actions are still being delineated, CARDIZEM is believed to act in the following ways:

1. Angina Due to Coronary Artery Spasm: CARDIZEM has been shown to be a potent dilator of coronary arteries both epicardial and subendocardial. Spontaneous and ergonovine-induced coronary artery spasm are inhibited by CARDIZEM.
2. Exertional Angina: CARDIZEM has been shown to produce increases in exercise tolerance, probably due to its ability to reduce myocardial oxygen demand. This is accomplished via reductions in heart rate and systemic blood pressure at submaximal and maximal exercise work loads.

In animal models, diltiazem interferes with the slow inward (depolarizing) current in excitable tissue. It causes excitation-contraction uncoupling in various myocardial tissues without changes in the configuration of the action potential. Diltiazem produces relaxation of coronary vascular smooth muscle and dilation of both large and small coronary arteries at drug levels which cause little or no negative inotropic effect. The resultant increases in coronary blood flow (epicardial and subendocardial) occur in ischemic and nonischemic models and are accompanied by dose-dependent decreases in systemic blood pressure and decreases in peripheral resistance.

Hemodynamic and Electrophysiologic Effects. Like other calcium antagonists, diltiazem decreases sinoatrial and atrioventricular conduction in isolated tissues and has a negative inotropic effect in isolated preparations. In the intact animal, prolongation of the AH interval can be seen at higher doses.

In man, diltiazem prevents spontaneous and ergonovine-provoked coronary artery spasm. It causes a decrease in peripheral vascular resistance and a modest fall in blood pressure and, in exercise tolerance studies in patients with ischemic heart disease, reduces the heart rate-blood pressure product for any given work load. Studies to date, primarily in patients with good ventricular function, have not revealed evidence of a negative inotropic effect; cardiac output, ejection fraction, and left ventricular end diastolic pressure have not been affected. There are as yet few data on the interaction of diltiazem and beta-blockers. Resting heart rate is usually unchanged or slightly reduced by diltiazem.

Intravenous diltiazem in doses of 20 mg prolongs AH conduction time and AV node functional and effective refractory periods approximately 20%. In a study involving single oral doses of 300 mg of CARDIZEM in six normal volunteers, the average maximum PR prolongation was 14% with no instances of greater than first-degree AV block. Diltiazem-associated prolongation of the AH interval is not more pronounced in patients with first-degree heart block. In patients with sick sinus syndrome, diltiazem significantly prolongs sinus cycle length (up to 50% in some cases).

Chronic oral administration of CARDIZEM in doses of up to 240 mg/day has resulted in small increases in PR interval, but has not usually produced abnormal prolongation. There were, however, three instances of second-degree AV block and one instance of third-degree AV block in a group of 959 chronically treated patients.

Pharmacokinetics and Metabolism. Diltiazem is absorbed from the tablet formulation to about 80% of a reference capsule and is subject to an extensive first-pass effect, giving an absolute bioavailability (compared to intravenous dosing) of about 40%. CARDIZEM undergoes extensive hepatic metabolism in which 2% to 4% of the unchanged drug appears in the urine. In vitro binding studies show CARDIZEM is 70% to 80% bound to plasma proteins. Competitive ligand binding studies have also shown CARDIZEM binding is not altered by therapeutic concentrations of digoxin, hydrochlorothiazide, phenylbutazone, propranolol, salicylic acid, or warfarin. Single oral doses of 30 to 120 mg of CARDIZEM result in detectable plasma levels within 30 to 60 minutes and peak plasma levels two to three hours after drug administration. The plasma elimination half-life following single or multiple drug administration is approximately 3.5 hours. Desacetyl diltiazem is also present in the plasma at levels of 10% to 20% of the parent drug and is 25% to 50% as potent a coronary vasodilator as diltiazem. Therapeutic blood levels of CARDIZEM appear to be in the range of 50 to 200 ng/ml. There is a departure from dose-linearity when single doses above 60 mg are given; a 120-mg dose gave blood levels three times that of the 60-mg dose. There is no information about the effect of renal or hepatic impairment on excretion or metabolism of diltiazem.

INDICATIONS AND USAGE

1. **Angina Pectoris Due to Coronary Artery Spasm.** CARDIZEM is indicated in the treatment of angina pectoris due to coronary artery spasm. CARDIZEM has been shown effective in the treatment of spontaneous coronary artery spasm presenting as Prinzmetal's variant angina (resting angina with ST-segment elevation occurring during attacks).
2. **Chronic Stable Angina (Classic Effort-Associated Angina).** CARDIZEM is indicated in the management of chronic stable angina. CARDIZEM has been effective in controlled trials in reducing angina frequency and increasing exercise tolerance.

There are no controlled studies of the effectiveness of the concomitant use of diltiazem and beta-blockers or of the safety of this combination in patients with impaired ventricular function or conduction abnormalities.

CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

WARNINGS

1. **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
2. **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.
3. **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
4. **Acute Hepatic Injury.** In rare instances, patients receiving CARDIZEM have exhibited reversible acute hepatic injury as evidenced by moderate to extreme elevations of liver enzymes. (See PRECAUTIONS and ADVERSE REACTIONS.)

PRECAUTIONS

General. CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

Drug Interaction. Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS).

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

Carcinogenesis, Mutagenesis, Impairment of Fertility. A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in in vitro bacterial tests. No intrinsic effect on fertility was observed in rats.

Pregnancy. Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers. It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, exercise caution when CARDIZEM is administered to a nursing woman if the drug's benefits are thought to outweigh its potential risks in this situation.

Pediatric Use. Safety and effectiveness in children have not been established.

ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences, as well as their frequency of presentation, are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%), AV block (1.1%). In addition, the following events were reported infrequently (less than 1%) with the order of presentation corresponding to the relative frequency of occurrence.

Cardiovascular:	Flushing, arrhythmia, hypotension, bradycardia, palpitations, congestive heart failure, syncope.
Nervous System:	Paresthesia, nervousness, somnolence, tremor, insomnia, hallucinations, and amnesia.
Gastrointestinal:	Constipation, dyspepsia, diarrhea, vomiting, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH.
Dermatologic:	Pruritus, petechiae, urticaria, photosensitivity.
Other:	Polyuria, nocturia.

The following additional experiences have been noted:

A patient with Prinzmetal's angina experiencing episodes of vasospastic angina developed periods of transient asymptomatic asystole approximately five hours after receiving a single 60-mg dose of CARDIZEM.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: erythema multiforme; leukopenia; and extreme elevations of alkaline phosphatase, SGOT, SGPT, LDH, and CPK. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established.

OVERDOSAGE OR EXAGGERATED RESPONSE

Overdosage experience with oral diltiazem has been limited. Single oral doses of 300 mg of CARDIZEM have been well tolerated by healthy volunteers. In the event of overdosage or exaggerated response, appropriate supportive measures should be employed in addition to gastric lavage. The following measures may be considered:

Bradycardia	Administer atropine (0.60 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously.
High-Degree AV Block	Treat as for bradycardia above. Fixed high-degree AV block should be treated with cardiac pacing.
Cardiac Failure	Administer inotropic agents (isoproterenol, dopamine, or dobutamine) and diuretics.
Hypotension	Vasopressors (eg, dopamine or levarterenol bitartrate).

Actual treatment and dosage should depend on the severity of the clinical situation and the judgment and experience of the treating physician.

The oral LD_{50}'s in mice and rats range from 415 to 740 mg/kg and from 560 to 810 mg/kg, respectively. The intravenous LD_{50}'s in these species were 60 and 38 mg/kg, respectively. The oral LD_{50} in dogs is considered to be in excess of 50 mg/kg, while lethality was seen in monkeys at 360 mg/kg. The toxic dose in man is not known, but blood levels in excess of 800 ng/ml have not been associated with toxicity.

DOSAGE AND ADMINISTRATION

Exertional Angina Pectoris Due to Atherosclerotic Coronary Artery Disease or Angina Pectoris at Rest Due to Coronary Artery Spasm. Dosage must be adjusted to each patient's needs. Starting with 30 mg four times daily, before meals and at bedtime, dosage should be increased gradually (given in divided doses three or four times daily) at one- to two-day intervals until optimum response is obtained. Although individual patients may respond to any dosage level, the average optimum dosage range appears to be 180 to 240 mg/day. There are no available data concerning dosage requirements in patients with impaired renal or hepatic function. If the drug must be used in such patients, titration should be carried out with particular caution.

Concomitant Use With Other Antianginal Agents:

1. **Sublingual NTG** may be taken as required to abort acute anginal attacks during CARDIZEM therapy.
2. **Prophylactic Nitrate Therapy** – CARDIZEM may be safely coadministered with short- and long-acting nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.
3. **Beta-blockers.** (See WARNINGS and PRECAUTIONS.)

HOW SUPPLIED

Cardizem 30-mg tablets are supplied in bottles of 100 (NOC 0088-1771-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1771-49). Each green tablet is engraved with MARION on one side and 1771 engraved on the other. CARDIZEM 60-mg scored tablets are supplied in bottles of 100 (NDC 0088-1772-47) and in Unit Dose Identification Paks of 100 (NDC 0088-1772-49). Each yellow tablet is engraved with MARION on one side and 1772 on the other.

Issued 4/1/84

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BOOK REVIEW

Book Review Editor — **F. Norman Vickers, M.D.**

Nine months reading: a medical guide for pregnant women

By Robert E. Hall, M.D., 178 pages. Price $13.95. Doubleday and Company, Inc.

There are many books, booklets, pamphlets, and guides written for women during their pregnancy. Some of these informational texts are written by physicians or nurses. Others are written by laygroups and pharmaceutical companies (with physician input). Those published by the pharmaceutical companies have been some of the best that I've read because they simply stick to the facts.

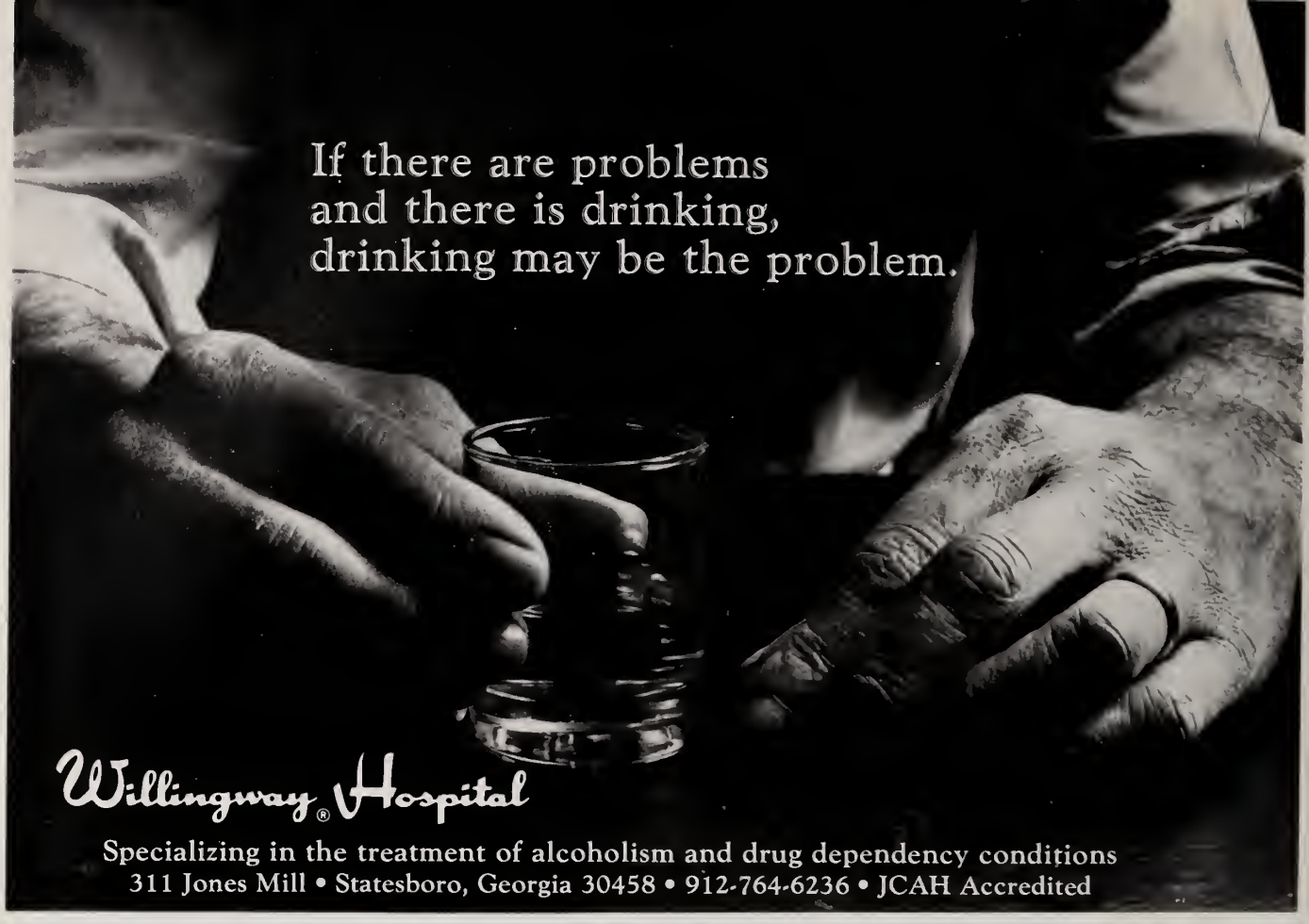
Dr. Hall's book is well written and leads the patient in a logical progression from early pregnancy through the postpartum period. This book gives the "mother-to-be" an overview of modern obstetrics and could be separated into four parts: 1) selection of physician and hospital; 2) prenatal period; 3) labor and delivery; and 4) postpartum period. The beginning chapters assist the reader in understanding the importance of seeking prenatal care for herself and her unborn child. Dr. Hall then takes the reader through a basic course in fetal development and the effects of pregnancy on anatomy. He discusses at length the common symptoms and sensations of pregnancy and devotes considerable time to diet, hazardous substances and exercise. A complete chapter is given to the possible complications of pregnancy during the prenatal course.

Having covered the prenatal period, the reader is taken through the process of normal labor and delivery with explanations of what is to be expected mentally, physically and medically. A chapter on abnormal labor and delivery, with a discussion of cesarean section, follows.

The book concludes with a description of the postpartum period and what the patient can expect in the hospital and at home. This section includes information to assist the mother in caring for and adjusting to her new baby. This particular book is as good as, and perhaps better than, many of the informational guides currently on the market today. However, the price is a bit high compared to many of the fine booklets given to patients by their obstetricians at no charge. Many of the pharmaceutical companies involved with products for prenatal and newborn care sell excellent booklets to physicians practicing obstetrics at a very reasonable cost and even personalize the book for the practicing physician. The physician generally includes the booklet in the packet of information given to the patient on her first prenatal visit.

It may be of interest to note that Dr. Hall is no longer a practicing obstetrician, having recently completed a residency in psychiatry. He, thus, has had to rely on consultation with colleagues for the latest medical information in obstetrics to revise the book.

Pierre J. Bouis Jr., M.D.
Tampa



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Auxiliary Liaison Editor — **Mrs. Walter (Isabella) Laude**

We care

This wonderful moment could never be happening if 27 years ago another wonderful thing had not happened. Twenty-seven years ago I became the spouse of a physician; thus, I became eligible for membership in this Auxiliary and now serving as your President.

Ours is a volunteer, service organization, but our purpose is no less dedicated. It is our purpose to assist physicians in protecting and improving public health and in providing good health education and health services to everyone.

Caring means recognizing our fellow human beings as persons who have value. Caring is a sense of shared humanity. CARE is protection, concern, and regard. Oh how I wish that those who would vilify our physicians as self-serving could but spend one day sharing their caring.

This is the beginning of our 60th year. We are faced with the realization that our system of the private practice of medicine is threatened. We must recognize the ever increasing urgency of our support of Auxiliary goals.

We dare not lessen for one moment our efforts in the support of AMA-ERF programs. The cost of medical education continues to rise and government continues to withdraw assistance and scholarships for fine young men and women who aspire to the profession. Our medical schools need our assistance of unrestricted funds to enrich and develop their programs. We can help with AMA-ERF.

We must emphasize the importance of our role in legislation. We must be politically aware and vigilant. Working together we can be a force that can help our physicians prevent a creeping bureaucracy from overcoming all of us.

We must be leaders in imparting health education to the public. The demand for information about health is insatiable. With health costs rising let us try to instill the need for disease prevention and make all aware of their responsiblity to themselves for their own good health.

We must keep Auxiliary membership in our thinking. Today more than ever we need the support of every physician's spouse. We must impress upon every physician the importance of spouse membership.

The county Auxiliaries symbolize the success and prestige of our organization. Local counties give impetus and purpose to Auxiliary life. Each has a task to do and a gift to bring, a local need which must be recognized and met. Each county gains strength and stature from the total good that is done by ALL AUXILIANS.

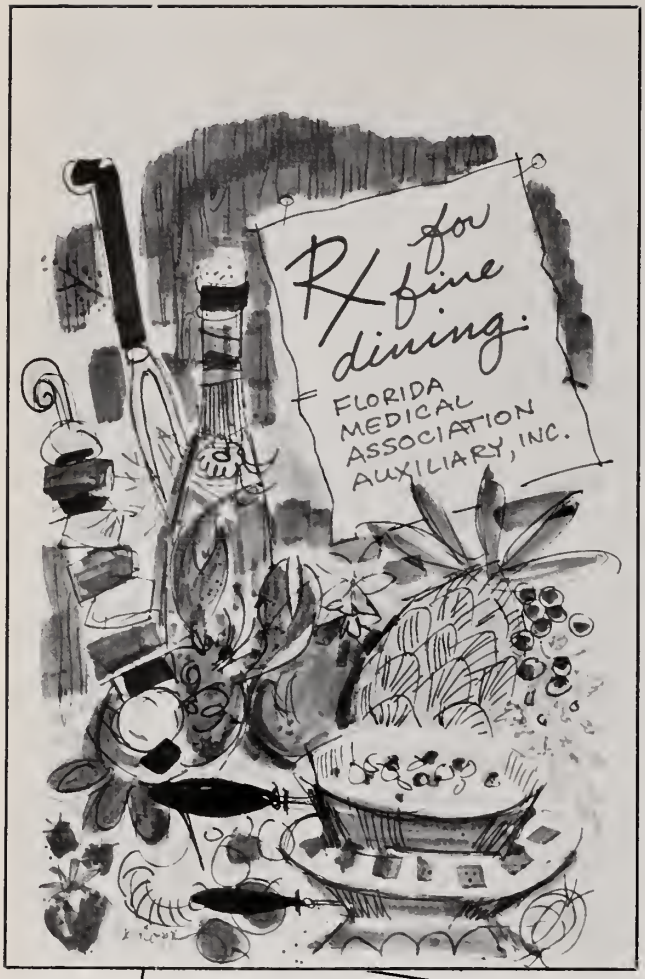
Let us begin this Auxiliary year with a sense of loyalty to our goals, a sense of dedication to serving to the best of our ability, a sense of cooperation with one another, and with other groups in our communities. Let our communities know that WE CARE about all that affects the well-being of every man, woman and child.

We here this day set the course — but it will be for all Auxilians to achieve our goals. WE CARE!

C — WE ARE CONCERNED
A — WE ARE AWARE
R — WE ARE RESPONSIVE
E — WE HAVE EMPATHY

WE CARE — AND OUR CARING IS THE KIND OF CARE WE AS AUXILIANS CAN GIVE.

Mrs. Milton (Jo) Tignor Jr.
President, FMA-Auxiliary
North Palm Beach



KEY LIME PIE

"This tried and true recipe is best with a graham cracker crust It's easy and can be done ahead!"

4 egg yolks, well beaten
1 can sweetened condensed milk
½ cup lime juice (4-6 limes)
*6 egg whites**
½ tsp. cream of tartar
¾ cup sugar
1 9" graham cracker pie shell, baked

In a small mixing bowl beat egg yolks until lemon-colored. Blend in condensed milk. Add lime juice, mix well. In a large mixing bowl beat egg whites and cream of tartar until foamy. Continue beating, adding sugar 1 tablespoon at a time until egg whites peak. Fold 6 tablespoons of meringue into the filling mixture. Pour into pie shell. Top with meringue and bake in a slow 330°F oven for about 30 minutes or until golden brown. Best served chilled. May be frozen and kept for a couple of days before serving.

*You can make the meringue with only 4 egg whites from the eggs you've used

Mrs. Michael John Murray (Candy)
Lee County

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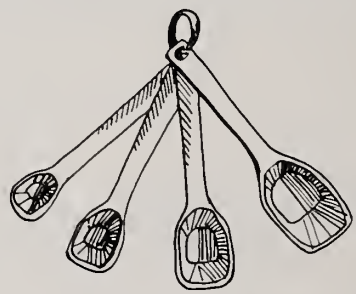
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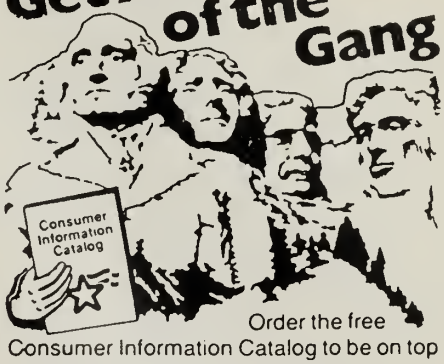
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Deaths

ALPERT, BARNETT B., Hollywood; born 1906; McGill University, 1932; member AMA; died 11/9/84.

ANDERSON, GEORGE H., St. Petersburg; born 1920; University of Maryland, 1945; died 12/25/84.

ANDERSON, HERBERT, C., Tallahassee; born 1926; Duke University, 1956; died 7/10/84.

ANSLEY, MARY KATHRYN, Longwood; born 1932; University of Tennessee, 1956; member AMA; died 4/29/84.

BECK, HOWARD J., Miami; born 1927; University of Lausanne, 1956; died 5/2/84.

BEJAR, RAFAEL LUIS, Miami; born 1936; University of Havana, 1961; died 12/2/84.

BISHOP, ROBERT C., Ft. Lauderdale; born 1928; University of Michigan, 1955; died 8/16/84.

BLACK, THOMAS C., Temple, Texas; born 1904; University of Kansas, 1930; member AMA; died 11/5/84.

BLACKBURN, JOHN T., Melbourne; born 1927; Bowman-Gray School of Medicine, 1958; died 6/7/84.

BOLIVAR, JUAN C., Tampa; born 1908; University of Paris (Sorbonne) and University of Havana, 1941; member AMA; died 9/3/84.

BOYLE, PLAYFORD JR., Sarasota; born 1924; Thomas Jefferson Medical School, 1954; died 8/5/84.

BRADLEY, JAMES L., Ft. Myers; born 1918; Yale, 1943; member AMA; died 2/1/85.

CHEN, BRUCE K. N., Hollywood; born 1940; National Defense Medical Center, Taiwan, 1965; member AMA; died 11/84.

CREWS, JOHN E., Orlando; born 1913; Col. Med. Evang., 1944; died 12/8/84.

EGAN, JAMES J., Daytona Beach; born 1932; Creighton University, 1957; member AMA; died 12/12/84.

ELKINS, MURRAY, Ft. Lauderdale; born 1908; Jefferson, 1933; member AMA; died 1/1/85.

ETTINGER, CHARLES D., Miami; born 1918; University of New York, 1950; member AMA; died 6/9/84.

FABIANI, FRANK R., Ft. Lauderdale; born 1913; University of Rome, Italy, 1941; died 8/84.

FARRIS, GEORGE WILLIAM, Stuart; born 1925; University of North Carolina and Washington University, 1948; member AMA; died 12/11/84

FISHER, LUTHER C., Pensacola; born 1907; Tulane University, 1930; member AMA; died 12/12/84.

FLIPSE, M. JAY, Miami; born 1896; Cincinnati Medical School, 1921; member AMA; died 8/18/84.

FRANK, RICHARD, Tamarac; born 1943; Columbia U. College of P&S, 1967; died 12/26/84.

FREEMAN, JOSEPH, Miami; born 1915; University of Louisville, 1943; member AMA; died 11/22/84.

GALLUCCIO, ANTHONY C., Hollywood; born 1902; New York University and Bellevue Medical College, 1927; member AMA; died fall of 1983.

GOLDBERG, MORRIS M., Hollywood; born 1906; New York Medical, 1930; member AMA; died 12/9/83.

GONCZY, EDWARD J., Sarasota; born 1908; University of Michigan, 1933; died 8/11/84.

GRUMER, HOWARD A., Miami; born 1932; University of Miami, 1958; died 10/9/84.

HARVEY, ROBERT A., Miami; born 1922; Western Reserve University, 1946; died 11/29/84.

HENRY, ARTHUR J. Jr., Tallahassee; born 1923; University of Alabama, 1947; member AMA; died 6/17/84.

HERNANDEZ, MARIO M., Miami; University of Havana and Salamanca University, 1964; died 5/25/84.

HOLLANDER, ASHER, Hollywood; born 1916; University of Maryland, 1941; member AMA; died 5/13/83.

HUMPHREYS, JACK, Miami; born 1912; University of Georgia, 1933; member AMA; died 8/16/84.

HUSTON, DOUGLAS E., Miami; born 1927; Temple University, 1957; member AMA; died 7/29/84.

KAPLAN, SAUL H., Miami; born 1906; University of Chicago, 1931; member AMA; died 7/2/84.

KENASTON, Thomas C. Sr., Cocoa; born 1903; University of Nebraska, 1927; member AMA; died 4/28/84.

LACY, GEORGE E., Miami; born 1913; Vanderbilt University, 1943; member AMA; died 6/17/84.

LESLIE, SAMUEL P., Miami; born 1911; University of New York, 1937; died 11/30/84.

LEVINE, SYDNEY, Miami; born 1930; University of Miami, 1959; member AMA; died 11/9/84.

LITTLEFORD, PHILIP O., Orlando; born 1939; John Hopkins, 1965; died 8/28/84.

LOPEZ, JUAN F., Miami; born 1904; University of Havana, 1927; died 7/79.

LORET DE MOLA, ALFREDO F., Miami; born 1926; University of Havana, 1952; died 3/27/84.

MAJOR, JAMES C., Miami; born 1930; Emory University, 1956; member AMA; died 1/24/85.

MACLURE, JOHN G., Miami; born 1921; Vanderbilt University, 1953; died 1/2/84.

MASKIN, MEYER H., Gainesville; born 1911; Wayne University, 1935; member AMA; died 6/18/84.

MAURY, ROBERTO L., Coral Gables; born 1923; University of Havana, 1950; died 5/22/84.

MCGEE, W. AMBROSE, West Palm Beach; born 1899; Medical College of Virginia, 1924; member AMA; died 6/4/84.

MCLAURY, ELBERT, Hollywood; born 1899; Emory University, 1925; member AMA; died 10/2/83.

MCSWAIN, GORDON H., Arcadia; born 1906; Harvard, 1932; member AMA; died 12/14/84.

MORAN, JAMES D., Bradenton; born 1923; Emory University, 1949; member AMA; died 8/2/84.

MOSES, ROBERT J. JR., Miami; born 1925; Loyola, 1948; member AMA; died date unknown.

NEEDLEMAN, HARRY, Miami; born 1913; Middlesex University, 1938; died 10/16/84.

PHILLIPS, KENNETH, Miami; born 1899; Rush Medical College, 1926; member AMA; died 7/7/84.

PRIDGEN, KIVY, L., St. Petersburg; born 1950; St. Louis University, 1977; member AMA; died 4/28/84.

PULTS, CARL M., West Palm Beach; born 1920; Emory University, 1945; member AMA; died 7/9/84.

PURCELL, JACK H., Ft. Lauderdale; born 1924; Indiana University, 1947; member AMA; died 9/16/84.

REICH, SAMUEL B., West Palm Beach; born 1902; New York University, 1927; died 4/3/84.

SAFFOS, ROSILIE O., Jacksonville; born 1940; University of Florida, 1967; died 8/29/84.

SAMS, WILEY M., Miami; born 1904; Michigan Medical School, 1929; member AMA; died 7/9/84.

SANDBERG, T. DOUGLAS, Miami; born 1903; University of Tennessee, 1926; member AMA; died 8/80.

SCHINDLER, JOHN A., Miami; born 1906; University of Illinois, 1932; died date unknown.

SHARP, CLARENCE M., Jacksonville; born 1902; Emory University, 1928; member AMA; died 5/30/84.

TIERNEY, NICHOLAS A., Miami; born 1910; John Hopkins, 1940; member AMA; died 11/12/84.

TRUPP, MASON, Tampa; born 1912; University of Maryland, 1937; died 1/6/85.

VINAS, JOSE B., Miami; born 1918; Havana University, 1943; died 6/21/84.

WEAVER, THOMAS D., Clermont; born 1927; Medical College of Georgia, 1953; died 12/84.

WELLS, W. DOTSON, Ft. Lauderdale; born 1911; University of Cincinnati, 1939; member AMA; died 1/21/85.

WHELCHEL, LYNN W., Miami; born 1908; University of Georgia, 1932; member AMA; died 12/30/84.

Heart Healthy Recipe

WILD RICE WITH MUSHROOMS

1 cup wild rice or long-grained rice and wild rice combined
⅓ cup green onions or shallots
1 cup fresh mushrooms
freshly ground black pepper
2 tablespoons oil
1 tablespoon margarine

Steam the rice or cook according to directions on the package.

Sauté fresh mushrooms and green onions in the oil. Stir in margarine and freshly ground pepper. Serve hot.

Yield: 6 servings
Approx. cal/serv.: 190

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WE'RE FIGHTING FOR YOUR LIFE

INFORMATION FOR AUTHORS

The Journal is the official publication of the Florida Medical Association. Its purpose and scope include not only the dissemination of scientific information but also communication of FMA activities and reportage of other subject matter relevant to the practice of medicine. Hence, the editors encourage submission of scientific papers (investigative studies, reviews, new technology, case reports); discussions of medical history and ethics; and articles dealing with socioeconomic, governmental, and legal issues as related to medicine.

Manuscripts should be submitted to Daniel B. Nunn, M.D., Editor of *The Journal*, Florida Medical Association, Post Office Box 2411, Jacksonville, Florida 32203, in original and three duplicate copies. Copies should be typewritten and double spaced.

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Getting back to basics is how we're helping put chronic pain sufferers back on the job.

Simple activities, such as baking, cleaning and painting, are helping grown men and women, many who suffer from work-related injuries, regain their dexterity, strength, and most importantly, their confidence.

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Our treatment is a smart choice for the patient and the physician. Because sometimes you've done all that can be done to alleviate the pain, yet the patient still suffers.

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The unit focuses on five major areas of pain rehabilitation: the actual reduction of pain; decreasing medication levels; increasing daily activities to improve the quality of life; the reduction of stress; and vocational counseling.

The unit's In-Patient Clinical Program involves eight critical areas of pain management, each with its own set of special techniques and goals: medical management, physical therapy, occupational therapy, social service, rehabilitation counselors, nursing, psychology, and recreational therapy.

For referral information please call (813) 972-7253, collect, or write to us at 3100 E. Fletcher Avenue, Tampa, Florida 33612.



Pain sufferers use biofeedback to monitor their stress levels.

Simple activities help the patient regain dexterity.

In Occupational Therapy, patients are taught to complete everyday tasks that have become difficult.

Patients use the whirlpool tank to relax muscles.

Exercising plays an important role in gaining strength and reducing pain.

The Pain Management Unit at University Community Hospital

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_____	016 Corticosteroids—Oral
_____	006 Coumarin-Type Anticoagulants
_____	005 Digitalis Medicines
_____	034 Ergot Derivatives
_____	010 Erythromycin
_____	026 Ethosuximide
_____	001 Furosemide
_____	024 Guanethidine
_____	022 Haloperidol
_____	023 Hydralazine
_____	035 Indomethacin
_____	015 Insulin
_____	038 Iron Supplements
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Clinical Conference on Prehospital Emergency Care, July 12-14, Orlando Hyatt, Orlando. For info: Registrar, 600 Courtland St., Suite 420, Orlando, 32804, (305) 628-4800.

Childhood Resuscitation & Stabilization, July 19-21, Orlando Hyatt, Orlando. For info: James V. Hillman, M.D., P.O. Box 18091, Tampa, 33679. (813) 251-6911.

First Annual Primary Care Review (in Spanish), July 22-26, Lincoln Hotel, Tampa. For information: Ian MacPhail, M.D., USF College of Medicine, 12901 N. 30th St., Box 13, Tampa, 33612, (813) 974-2309.

Vascular and Pulmonary Disease: Diagnosis and Management, July 26-28, Orlando Hyatt, Kissimmee. For information: Stephen Mattingly, 5808 S. Rapp Street, Littleton, CO 80120, (303) 798-9682.

Twelfth Annual Review Course for Certification of Internal Medicine, July 28-Aug. 10, Sheraton Bal Harbour, Miami. For information: Jose S. Bocles, M.D., University of Miami, Department of Medicine, P.O. Box 016960, Miami, 33101, (305) 547-6063.

AUGUST

Controverises in Carcinoma of the Breast, August 7-10, Hyatt Regency Grand Cypress, Orlando. For more information, contact: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, 813-974-2538.

Tips, Tricks, Traps and Techniques, August 16-18, Amelia Island Plantation, Amelia Island. For information contact: Beverly Tyson, 655 W. 8th Street, Jacksonville 32209, 904-739-2338.

Arrhythmias: Interpretation, Diagnosis and Management, August 16-18, Orlando Hyatt, Orlando. For information call: Stephen Mattingly, 1-800-421-2323.

SEPTEMBER

International Symposium on Gynecologic Oncology, Surgery and Urology, Sept. 23-27, Germany. For more info: William A. Little, M.D., Deparment of Obstetrics and Gynecology, P.O. Box 016960, Miami 33101, 305-549-6944.

Ninth Annual Medical Aspects of Aging, September 27-28, University of Florida, Gainesville. For information, call: Grace Wagner, JHMHC J-233, Gainesville 32610, (904) 392-3143.

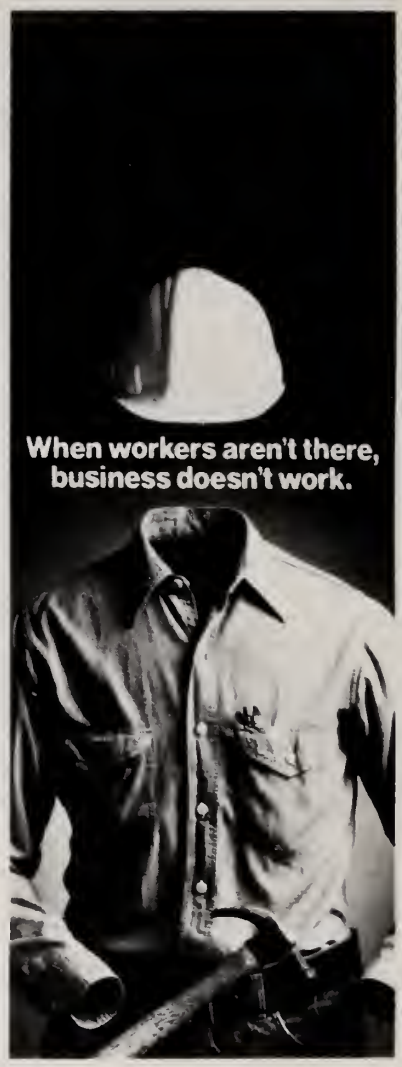
OCTOBER

Advanced Neruoradiology Seminar, October 16-19, Hilton Hotel, Lake Buena Vista. For information: Charleen Krissman, 12901 N. 30th Street, Tampa 33612, (813) 974-2538.

Thirty-ninth Regional Family Practice Weekend, October 25-27, Marriott Biscayne Bay Hotel, Miami. For information: Charles A. Dunn, M.D., 4057 Carmichael Ave., Suite 229, Jacksonville 32207, (904) 398-5667.

Fall 1985 Family Practice Review, October 27-November 2, Orlando. For information: Grace Wagner, JHMHC, J-233, Gainesville 32610 (904) 392-3143.

Nutrition In Pediatric Practice, October 30-November 1, Don Cesar Resort, St. Petersburg. For information: Herbert Pomerance, M.D., JHMHC, J-15, Tampa 33612, 813-974-4214.



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FAMILY PRACTICE OR EMERGENCY MEDICINE physician opening in a private freestanding emergency center. Excellent location. Highly attractive practice setting. Send CV to: Michael J. Webb, M.D., Harrell Medical Center, 1805 SE Lake Weir Avenue, Ocala, FL 32627 or call (904) 629-0642.

GERIATRIC OR FAMILY PRACTICE physician wanted in Central Florida. Ideal practice situation. Reply to: C-1202, Post Office Box 2411, Jacksonville, FL 32203.

GENERAL INTERNISTS, PEDIATRICIANS,AND FAMILY PRACTITIONERS: Expanding 30 man physician multispecialty group in West Palm Beach, Fla. seeks dynamic, Florida licensed, fully American trained physicians for private practice 1985. Candidates must be personable and well qualified; emphasis on high quality patient care. Send CV and references with letter outlining your goals to: C-1249, Post Office Box 2411, Jacksonville, Fl 32203.

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BOCA RATON & NORTH BROWARD AREA — Opportunity for primary care (IM, FP, OB/GYN) physicians to join successful, growing prepaid healthplan opening offices in highly desirable area. Enjoy excellent compensation and benefits package. Send CV and references to C-1274, P.O. Box 2411, Jacksonville, FL 32203.

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ST. PETERSBURG: Opportunity for experienced emerging physician in low-volume E.D. on Florida's Gulf Coast. ACLS essential, ATLS encouraged. Send C.V. to S. MacLeod, M.D., 8601 Merrimoor Blvd., E., Largo, FL 33543, or call 813/397-7234.

ESTABLISHED FAMILY PRACTICE opportunity on the Gulf Coast of Florida (Sarasota/Bradenton). Seeking primary care, board certified physician in Family Practice to compliment existing 3 physicians. Office has in-house laboratory and x-ray facilities with emphasis on high quality patient care. Built in patient referral system. Share call every 4th night, 4th weekend, and rotating holidays. Reply with CV to: Occupant, P.O. Box 14204, Bradenton, FL 34280-4240.

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FLORIDA S.E. COASTAL AREA UNIQUE OPPORTUNITY for someone with Internal Medicine and Emergency Medicine experience. Expanding office based practice-opportunity with equity participation available. Send C.V. in confidence to: SRM & Associates, Inc., 1060 NE 28th Terrace, Pompano Beach, FL 33062.

FAMILY PHYSICIAN, Board certified, to join a well established solo practice in Central Florida. Initial salary with early opportunity for partnership. For further information, please call (813) 859-2748.

INTERNAL MEDICINE: Full-time opportunity for board certified physician. For further information, contact Dr. C.W. Silverblatt, Chief, VA Outpatient Clinic, 83 W. Columbia, Orlando, FL 32806, (305) 425-7521. The VA is an equal opportunity employer.

PSYCHIATRIST — full-time position open for board certified or eligible psychiatrist. To provide direct services and consultation for interdisciplinary staff in the treatment of adult and geriatric population. Outpatient only. Florida license needed. Write or call: A. Mullin, M.D., Mental Health Clinic of Jacksonville, Inc., 2627 Riverside Ave., Jacksonville, Florida 32204, (904) 384-2364.

MEDICAL DIRECTOR — ORLANDO AREA. Patient care and administrative leadership for migrant and rural primary care centers. Family medicine and experience in supervision and quality assurance desired. Salary commensurate with qualifications and excellent benefits. Send CV, salary expectations, and 3 references to Cecilia ABT, P.O. Box 1249, Apopka, Fl. 32703.

PLASTIC AND RECONSTRUCTIVE COSMETIC SURGEON; Outpatient facility opening in Miami seeks cosmetic surgeon on a full or part-time basis. Send CV to PBC number one, 375 South County Road, Palm Beach, FL 33480.

PHYSICIANS: Progressive, physician-owned medical group has positions available in the SE Florida area. Experienced, Board-prepared or Board certified physicians are preferred with interests in primary care, internal medicine, emergency and critical care medicine. Competitive salary, fringe benefits, paid malpractice insurance. Call (305) 325-1381 or send CV to Emergency Medical Group, P.A., 1400 NW 12 Ave., Miami, FL 33136.

GERIATRICIAN/FAMILY PHYSICIAN needed to join and augment an established program in geriatrics and gerontology at the major teaching and research hospital in Jacksonville, Fl. Program to include teaching of fellows, residents, medical students, nurses and participation in multi-departmental clinical research activities. Strong city and community support. Faculty appointment, University of Florida. Competitive salary. Excellent fringe benefits. Exceptional recreational and cultural activities. Send CV to John A. Grisnik, Jr., M.D., Dept. of Community Health and Family Medicine, University Hospital of Jacksonville, 655 West Eighth Street, Jacksonville, FL 32209, (904) 350-6510.

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Situations Wanted

AVAILABLE CARDIOLOGIST-INTERNIST from July 1985. Invasive-noninvasive, FMG, ABIM certified. Reply: Vijay Vakharia, M.D., 2727 North Pine Grove, Chicago, IL 60614, or call evenings (312) 477-0560.

BOARD CERTIFIED PEDIATRICIAN, Florida licensed, seeks group practice in Florida. C-1227, P.O. Box 2411, Jacksonville, Fl 32203.

ORTHOPEDIST, 54, Florida license, seeks work in office with a busy orthopaedic group, anywhere in Florida. No malpractice evaluations, except in defense (of physician). Reply to: Orthopedist, 3043 South Atlantic Avenue, #401, Daytona Beach Shores, FL 32018. Phone: (904) 761-1738.

ANESTHESIOLOGIST: ACA certified seeding practice opportunity in Fla. solo or group. Available immediately. Reply: Oscar Gonzalez, 6940 Sunrise Dr., Coral Gables, FL 33133, (904) 666-2371.

ANESTHESIOLOGIST: Florida licensed, B/E, completing fellowship in anesthesia Dec. 1985, available at anytime, experience in all kinds of anesthesia, desire any type of opportunity anywhere in Florida. Reply: B. Patel, M.D., 133-52 Avery Ave., Flushing, N.Y. 11355 or call evenings (718) 445-6679.

INTERNIST FINISHING residency training and Board eligible July 85 looking to join solo practitioner or group. Jeffrey Sklar, M.D., 314 Newark Ave. Apt. 6, Bradley Beach, New Jersey 07720.

FAMILY PRACTITIONER, Board Certified with extensive private practice and academic experience. Florida license. Relocating to Florida 1986. Seeking quality position, private practice, hospital or academic. Edward H. Davis, M.D., 315 Beach 143 Street, Neponsit, N.Y. 11694.

ANESTHESIOLOGIST: 36, Florida licensed, in process of ABA Certification, Fellowship in Pain Management, group practice last two years, extensive experience in Regional Anesthesia, desires to settle in Florida, consider any opportunity, Available anytime. Reply: Dharia, M.D., 67-02 230th St., Bayside, N.Y., 11364, 718-225-5804.

LOCUM-TENENS work wanted in primary care facility, or office practice. Coverage provided by licensed and insured physicians. Radiologists also available. Call 1-800-545-4141, Ext. 257.

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RADIOLOGY: Private Practice est. 4 years. Downtown Jacksonville, Florida. Grossing $160,000.00 with excellent growth potential. Purchase price negotiable. Sergio Lagman, M.D., 600 N. Church St. Lake City Fl 32055.

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INTERNAL MEDICINE practice for sale in Central Florida, about 80 south of Disney World. Board Certified Internist wishes to retire after 26 years of active practice. Prefer Internist with sub-specialty of Cardiology. Reply to Box C-1269, P.O. Box 2411, Jacksonville, FL 32203.

OTOLARYNGOLOGY practice, established 27 years. Patients records, equipment and office available. Price negotiable. Otolaryngologist, Suite E, 500 Memorial Circle, Ormond Beach, FL 32074.

SHARE MEDICAL-SURGICAL office fully furnished, five and a half days each week. Includes waiting room, business office, lab, three exam rooms. P.E. Callaghan, M.D., 1500 E. Hillsboro Blvd., Deerfield Beach, FL 33441, (305) 428-2420.

UROLOGIC PRACTICE FOR SALE. N. Central Florida. Have just retired. Same location over thirty years. Office equipment for sale. Lovely two-man urologic building adjacent to local hospital also for sale. Florida license is essential. Reply Box C-1273, P.O. Box 2411, Jacksonville, FL 32203.

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PEDIATRICS — North Fl., well established, fully equipped, centrally located, hospitals nearby, good clientele, quality practice, charts, equipment, goodwill transferable; office building for purchase or rent, terms flexible, BE/BC, contact C-1275, P.O. Box 2411, Jacksonville, FL 32203.

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SHARE OR OFFICE SPACE available in medical complex with pharmacy and lab. Convenient to all Orlando hospitals. Call 305-898-3451.

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GAINESVILLE, Bellamy Forge, 3 BR, 2½ B, attached garage, condo with all amenities, mint condition, $56,500.00. (813)254-3412.

ACTIVE FAMILY PRACTICE, 30 to 40 patients per day, has office space available for medically related business or expansion for specialist in Dunnellon, Fl. Please call for appointment, 904-489-2401 or 904-489-0598.

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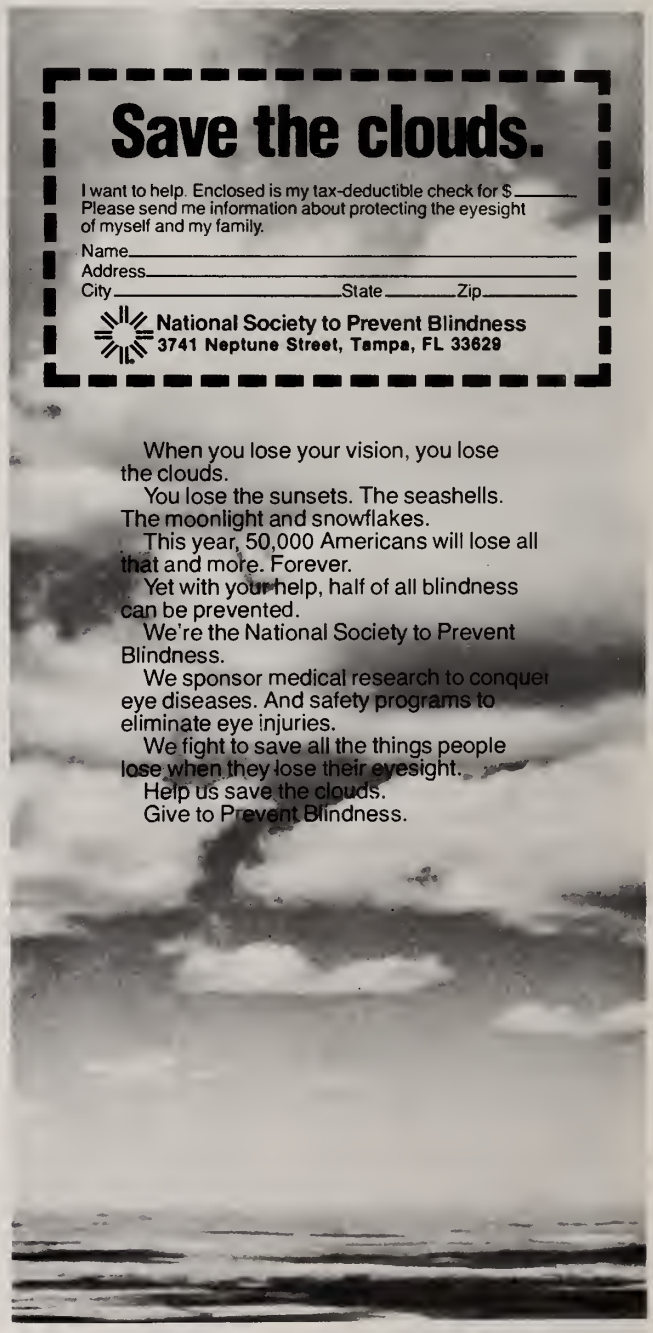
THE CONTROVERSIES IN CARCINOMA of the Breast Seminar sponsored by the Department of Radiology at the University of South Florida College of Medicine will be held at the Hyatt Regency Grand Cypress, Orlando, Aug. 7-10, 1985. The course will present the latest diagnostic imaging, radiation oncology, chemotheurapeutic, and surgical approaches to breast disease. Guest faculty will include Drs. Feig, Janus, Recht, and Urban. The fee is $330 for 16 Category I Credit Hours. Call Charleen Krissman (813) 974-2538 for more information.

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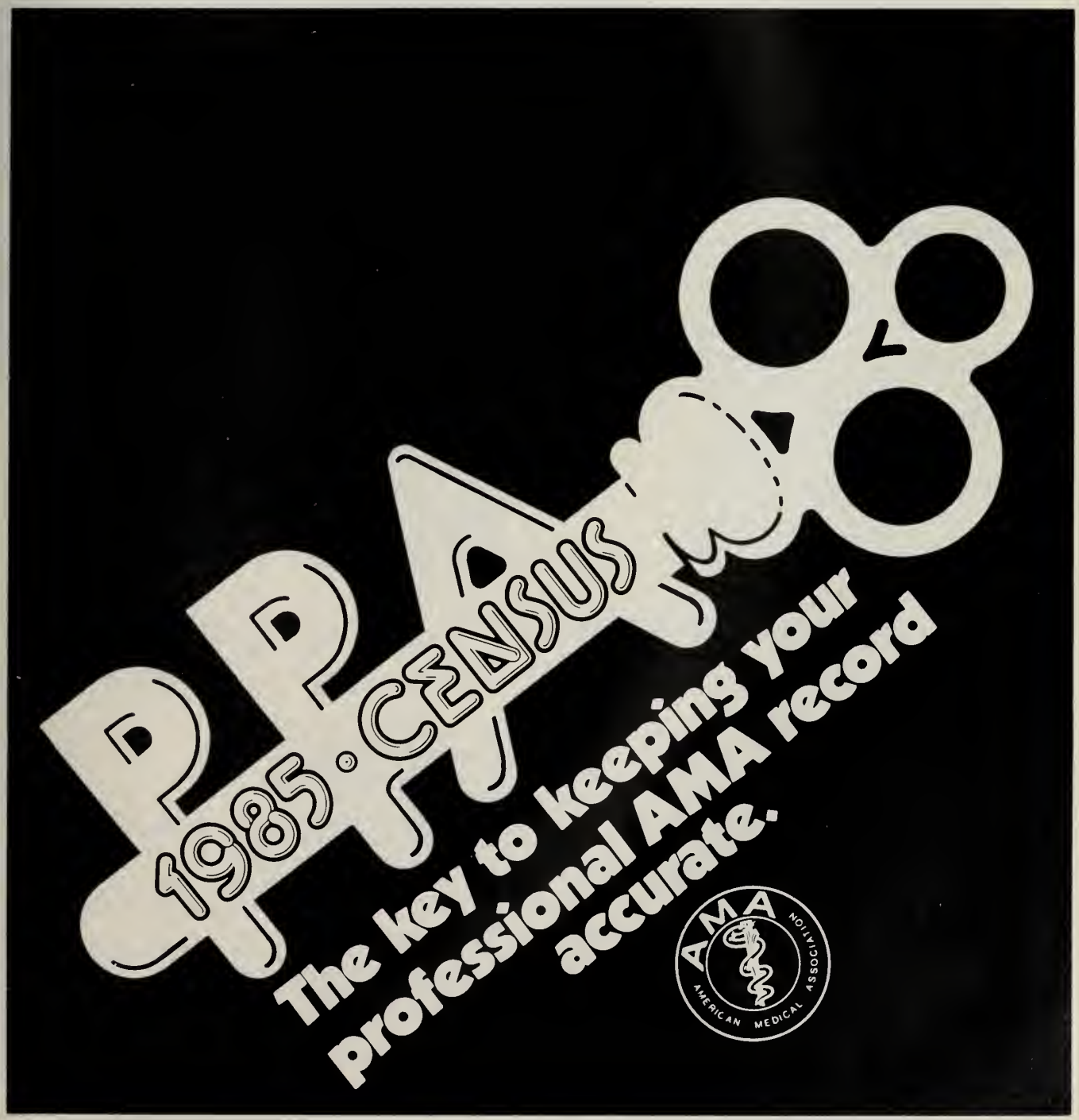
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Caution patients about driving, operating hazardous machinery or drinking alcohol during therapy. Limit dose to 15 mg in elderly or debilitated patients. Contraindicated during pregnancy.

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References: 1. Kales J *et al*: *Clin Pharmacol Ther 12*:691-697, Jul-Aug 1971. **2.** Kales A *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975. **3.** Kales A *et al*: *Clin Pharmacol Ther 19*:576-583, May 1976. **4.** Kales A *et al*: *Clin Pharmacol Ther 32*:781-788, Dec 1982. **5.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. **6.** Kales A, Kales JD: *J Clin Pharmacol 3*:140-150, Apr 1983. **7.** Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther 21*:355-361, Mar 1977. **8.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **9.** Amrein R *et al*: *Drugs Exp Clin Res* 9(1):85-99, 1983. **10.** Monti JM: *Methods Find Exp Clin Pharmacol 3*:303-326, May 1981. **11.** Greenblatt DJ *et al*: *Sleep 5*(Suppl 1):S18-S27, 1982. **12.** Kales A *et al*: *Pharmacology 26*:121-137, 1983.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

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